84-1601

No. ——

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

AETNA LIFE INSURANCE CO.,
Appellant,

v.

MARGARET W. LAVOIE AND ROGER J. LAVOIE, SR.,
Appellees.

Appendix to Jurisdictional Statement on Appeal From the Supreme Court of Alabama

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APPENDIX FOR APPELLANT

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APPENDIX A

THE STATE OF ALABAMA — — — — JUDICIAL DEPARTMENT

THE SUPREME COURT OF ALABAMA

OCTOBER TERM, 1984-85

82-426 & 82-1152

AETNA LIFE & CASUALTY CO., INC.

v.

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.

APPEALS FROM MOBILE CIRCUIT COURT

[Filed Dec. 7, 1984. Clerk, Supreme Court of Alabama]

PER CURIAM.

These cases, involving a claim of bad faith refusal to pay an insurance claim, have been before this court on two previous occasions. *Lavoie* v. *Aetna Life & Casualty Co., Inc.*, 374 So. 2d 310 (Ala. 1979); *Lavoie* v. *Aetna Life & Casualty Co., Inc.*, 405 So. 2d 17 (Ala. 1981). On the first appeal, we reversed the trial court's granting of the defendant/insurer's motion to dismiss for failure to state a claim. On the second appeal, we reversed the trial court's summary judgment for the defendant on two bad faith refusal to pay counts and summary judgment for the plaintiff on the contract counts.

In the instant cases, the insurer "admit[ted]" at the close of the plaintiff's evidence that the plaintiff had "made out a *prima facie* case to recover" on the contract of insurance, but moved for a directed verdict on the bad faith counts. The trial court denied the motion. The case went to the jury on two counts of bad faith refusal to pay, and on the contract claim. The jury was out for fifty minutes and returned a verdict for the plaintiffs in the sum of $3,501,650.22, of which sum $3,500,000 was for punitive damages. The defendant filed motions for judgment not-

withstanding the verdict, or in the alternative, remittitur, or in the alternative, for a new trial. The trial judged denied the motions. The question presented on this appeal is whether the evidence presented a jury question on the tort of bad faith refusal to pay an insurance claim.

THE EVIDENCE

The plaintiffs, Margaret and Roger Lavoie, are husband and wife. Mrs. Lavoie was insured as a dependent under a group policy of health and medical insurance issued by the defendant, Aetna Life and Casualty Company, Inc., (hereinafter Aetna). Mr. Lavoie had been a policeman for the City of Mobile, but was retired on disability because of a brain tumor. The plaintiffs lived approximately forty miles from Mobile at the time this claim arose.

Mrs. Lavoie was examined by John B. Douglas, M.D., at his office on or around 31 January 1977. Mrs. Lavoie had telephoned Dr. Douglas and requested the examination. Upon her arrival at his office, Dr. Douglas arranged for Mrs. Lavoie to proceed directly to an examination room, rather than waiting, as was customary. Dr. Douglas testified this was done because of his concern over the symptoms Mrs. Lavoie had related to him in the telephone conversation. After an examination of Mrs. Lavoie, Dr. Douglas recommended to both Mr. and Mrs. Lavoie that Mrs. Lavoie be admitted to the Mobile Infirmary Hospital. The hospital was "full" so arrangements were made for admission when a room came available. Mrs. Lavoie was admitted to the hospital on 3 February 1977.

On the day of admission, Dr. Douglas dictated a "History and Physical Summary." In pertinent part this summary reads:

> "This 54 year old lady has been followed in the past for mechanical low back pain and osteoarthritis. She had not been seen in our office in about 3 years. She came in with the interval history that she had been

retired for 2 years, that her arthritis had become more active over the last several months and she was having generalized arthritis pains in her back, neck and all extremities particularly in the hips, left knee and around the pelvic area. She complains of being very nervous. She said that she has been noticing som intermittent bleeding from the bowel and has a past history of diagnosis of chronic ulcerative colitis. Because of the general exacerbation of her arthritis and the apparent exacerbation of her ulcerative colitis, she is admitted at this time for evaluation and treatment.

"PAST HISTORY: She had gall bladder surgery in 1970, a fibroid tumor removed in 1946 and an exploratory laparotomy in 1953. She has a history of a couple episodes of pnemonia [sic] but denies history of peptic ulcer, hepatitis, rheumatic fever, diabetes or hypertension. She has a questionable history of glaucoma, does not know the severe state of it. She has had episodes of chest pain in the past, about 4 years ago, none recently. No diagnosis or EKG's were done at the time of the pain.

"FAMILY HISTORY: Positive for hypertension and she has a brother who had 1 episode of what was called inflammatory arthritis as a child. No family history of cancer, diabetes or early heart disease."

Mrs. Lavoie was in the hospital a total of twenty-three days. During this period, Dr. Douglas, or his partner, ordered medical diagnostic tests to be completed on Mrs. Lavoie, an electroencephelogram (EEG), and electrocardiogram (EKG), a gastrointestinal series (GI series), a barium enema, a computer assisted tomogram (CAT scan) and various other tests. During her stay in the hospital, Mrs. Lavoie complained of headaches, dizziness, diarrhea, nervousness, problems with her family, blood in her stools, pain in her abdomen, joint pain, and shortness of breath.

The evidence shows that Aetna had knowledge of these complaints before it finally denied the claim.

Dr. Douglas dictated a "discharge summary," after Mrs. Lavoie's discharge on 26 February 1977, which reads in full:

> "54-year-old white female who was admitted with an abdominal pain, osteoarthritis and mechanical low back pain. She had not been seen in my office for three years when she came in because of general aching and particularly saying that she had had intermittent bleeding from the bowel and had a past diagnosis of chronic ulcerative colitis. We are unable to substantiate this diagnosis in the hospital. In fact, she had a negative GI workup. Her musculoskeletal complaints while she does have some normal amount of osteoarthritis varying from place to place for her age, it is not really outstanding and her general situation suggests that she considerable [sic] psychogenic overlay to her somatic symptoms, and therefore, they are somewhat exaggerated. She has been placed on Mellaril in depth. She has shown some suggestion of slight improvement in the hospital but continues to somaticize her symptoms rather vigorously. It has been explained to her that this is primarily a nervous problem and we have mentioned that she may need the help of a psychiatrist if she does not continue to improve following discharge.
>
> "DISCHARGE DIAGNOSIS: OSTEOARTHRITIS,
> MILD
> PSYCHOPHYSIOLOGIC
> REACTION
> MANIFESTED BY
> ABDOMINAL PAIN."

On 3 March 1977, the hospital completed the appropriate forms and forwarded them along with the two summaries, the physician's progress notes and various other data such

as the consultation on the EKG, to the Aetna office in Mobile. Included was a bill for $3,028.25. The supervisor of the Mobile office of the insurer, Alice Murphy, sent a request to the hospital for further information on 24 March 1977. This letter in pertinent part read:

> "It would be greatly appreciated if you would send complete hospital records including, admitting and discharge summary, nurses and physicians notes."

On 5 April 1977, *before receiving* anything further from the hospital, Brenda Harris, a claim worker for Aetna, forwarded the information she had from the hospital to Jean Becker, a "Senior Claims Examiner," in Aetna's office in Hartford, Connecticut. To the information forwarded, Harris appended a memorandum stating:

> "In our opinion a 23-day confinement for the diagnosis was not necessary. Hospital records do not indicate anything to the contrary."

In pertinent part, Aetna's response reads:

> "DATE: April 27, 1977
>
> ". . . .
>
> "This file has been reviewed with a member of the Medical Dept. On the basis of the limited information submitted, this confinement does not appear to have been medically necessary. We feel this patient could have been evaluated and treated on an out-patient basis.
>
> "Several of the X-ray and lab procedures performed are not usual and customary for the diagnsois given. These include the CAT scan, EEG and EKG. Since the City of Mobile policy clearly limits coverage to services and supplies which are reasonably necessary for the diagnosis and treatment of nonoccupational disease or injury, room and board charges as well as the aforementioned miscellaneous charges must be denied. Thank you."

The Lavoies received notification, by a letter from Harris, on 3 June 1977, which reads in full:

> "After having this file reviewed by our Medical Department we must, at this time, deny benefits for room and board charges.
>
> "From the information we submitted to them it appears the evaluation and test could have been performed on an out-patient basis. Also, we must deny charges for the CT Brain Scan, EEG and EKG since they are not usual and customary procedures for the diagnosis given.
>
> "If you have any questions please feel free to contact this office."

The defendant then paid $1,057.20 to the hospital for the medical diagnostic tests, other than the EEG, EKG, and CAT scan, and did not pay for physical therapy and a back brace. Dr. Douglas was paid $305.20 and the Lavoies were paid $217.34 directly. The parties stipulated the remainder on the claim was $1,650.22.

On 4 November 1977, Dr. Douglas wrote a very detailed medical report to Thomas J. Stein, Mrs. Lavoie's attorney at the time: It reads:

> "Mrs. Lavoie was first seen here in 1973 and we continued seeing her on a regular basis for several months until January of 1974. At that time she had complaints of 'muscular rheumatism.' She was concerned about severe medical illnesses such as muscular distrophy and multiple sclerosis because of her muscular pains. she was reassured that her problem was nothing of that nature.
>
> "Her past history at that time was that three years previously she had been given the diagnosis of chronic ulcerative colitis. She was not under treatment for

this when I saw her and was not having any problems as regards this. I thought she had a mechanical low back pain and a chronic anxiety syndrome.

"She disappeared from follow-up on January 3, 1974 and did not return until January 3, 1977. At that time she told me she had been retired for two years; and her arthritis was bothering her all over. It was in her hips, her left knee, her pelvis, and she was also very nervous. She reported having had bright red bleeding from the bowels. She was quite anxious, seemed to have flight of ideation, and changes in personality which I had not noted when I had seen her previously.

"Because of this she was admitted to the hospital for studies which were appropriate for personality change. These included CT Brain Scan, and EEG. All tests were negative and we felt that this was a rather severe anxiety syndrome and with the negative general workup felt that she was having a psychophysiologic reaction manifested by abdominal pain and anxiety.

"I believe that this summary shows that the workup which was done was appropriate in ruling out organic and abdominal disease and also organic intracranial disease. I hope this clears the matter to your satisfaction."

This letter was introduced into evidence. There was an unsigned notation on the letter from Dr. Douglas, which Harris testified she had made after a telephone conversation with Tom Hutton, a senior claims examiner in the Hartford, Connecticut office. The notation reads:

"11/9 Called Tom Hutton HO [home office] he said maintain denial—if they act like they are going to file suit send back to him."

Harris further testified that she had read Dr. Douglas's letter to Hutton over the telephone and that the notation was an indication of Hutton's decision. Harris testified, as did Hutton, that no one else in the Connecticut office reviewed the letter from Dr. Douglas.

On 14 November 1977, Harris, by letter to the Lavoies' attorney, again denied the remainder of the claim.

> "Thank you for the copy of the letter sent to you November 4, 1977, by Dr. Douglas since we had tried unsuccessfully on several occasions to get a letter from him. However, Dr. Douglas does not give us any information in his letter that we did not have in our copies of the hospital records. He does not state why the test had to be done as an inpatient nor why a 23 day hospital confinement was necessary. The test on the hospital order sheets were tests that could have been done as an outpatient. The doctor, in his letter and in his hospital records, does not give any indication as to why he could not have done the test as an outpatient.
>
> "Without some further information from the Doctor as to why hospital confinement was medically necessary, we must maintain our denial."

The Lavoies' attorney then had Dr. Douglas write another letter and forwarded it to Harris. This letter read:

> "I don't know of anything further I can say to establish that inpatient care was necessary for the testing and treatment of Mrs. Lavoie. Let me again point out the personality change in Mrs. Lavoie. In my best judgment she needed the controlled atmosphere of the hospital for observation and to carry out necessary testing."

An unsigned notation on the second letter read:

> "12/20 Called Tom Hutton. He stated continue to deny claim on info available to us —"

Harris testified this was her handwriting and was an indication of a telephone call she made to Hutton in the Hartford office. She testified she had read Dr. Douglas's second letter to Hutton, after which he again instructed her to deny the claim. Mrs. Harris wrote to the Lavoies' attorney on 23 December 1977, informing them of the denial:

> "Thank you for your letter of December 19, 1977, with its attachment.
>
> "I have again checked with our Medical Department on this matter and they have advised that, based on the information available to us, we must continue to deny any benefits for the room and board.
>
> "If there is any additional information which might alter our decision, we would be most happy to consider it."

On 8 April 1978, Aetna's Mobile office wrote to the Mobile Infirmary requesting the nurse's notes which were then mailed to the Mobile office of Aetna. In turn, these nurses' notes were forwarded to R. E. Mann, a senior claims examiner in Hartford, who placed them with the admission and discharge summaries, physician's progress notes and physician's orders. He sent them to Aetna's Doctor Swan of the Medical Department, accompanied by his notation:

> "(D) We now have nursing notes, which we did not have for the original review.
>
> "Question: Should we change our original decision, based on the nurse's notes?
>
> "Opinion: No. The nurse's notes do not indicate that in-patient confinement was medically necessary.
>
> "R. E. Mann"

The two letters from Dr. Douglas *were not* in the file reviewed by Dr. Swan.

On 28 July 1978, Mann informed the Mobile office of another denial:

> "[I]n response to your memo dated July 10, 1978, forwarded to Tom Hutton about the above claimant. . . .
>
> "*Opinion*
>
> "We should maintain our original claims determination for the charges incurred by Mrs. Lavoie related to her confinement and services of Feb. 3 through Feb. 25, 1977.
>
> "*Rationale*
>
> "Our Home office Medical Staff has again reviewed this claim including the nurse's notes. They advise that in their opinion, in-patient confinment was not indicated for the claimant's wife's condition. The necessary test and evaluations could have been performed on an out-patient basis.
>
> "*Suggested Course of action*
>
> "Please advise the claimant with a copy to his attorney that his claimant has been again reviewed by our Home office Medical Staff. Under the group coverage, they still believe that our original benefits determination was correct."

Aetna's Mobile office informed the Lavoies of that last denial by letter dated 3 August 1978.

The provisions of the insurance contract, pertinent to this case, are:

"ARTICLE II—BENEFITS

"COVERED MEDICAL EXPENSES

"Covered Medical Expenses are the reasonable charges which an employee is required to pay for the following services and supplies received by a covered family member for the necessary treatment of any non-occupational injury or non-occupational disease:

"HOSPITAL EXPENSES: These are the charges made by a hospital, in its own behalf, for (a) Board and room. . . .

". . . .

"EXCLUSIONS, LIMITATIONS AND PROVISIONS APPLICABLE TO ALL TITLES UNDER ARTICLE II

". . . .

"No insurance is afforded under any Title of Article II as to charges

". . . .

"(5) for care, treatment, services or supplies which are not necessary for the treatment of the injury or disease concerned nor to the extent that any charges for care, treatment, services or supplies are unreasonable. . . ."

Aetna raises four issues on appeal:

"(1) Whether the plaintiffs met their burden of proof on the bad faith refusal claim;

"(2) Whether the partial payment made by Aetna precluded a finding of bad faith refusal to pay;

"(3) Whether the evidence adduced at trial was sufficient to support an award of punitive damages in the amount of $3,500,000 against Aetna;

"(4) Whether the trial court erred in allowing the plaintiff, Roger Lavoie, to give testimony, over Aetna's objection as to the plaintiff's poor financial condition."

Under the evidence in *this* case, questions one and three must be answered in the affirmative. Questions two and four must be answered in the negative.

I

The evidence is overwhelming that Aetna acted in bad faith. Its conduct placed it squarely within the definition of bad faith as stated by Justice Beatty in *Gulf Atlantic Life Insurance Co.* v. *Barnes,* 405 So. 2d 916 (Ala. 1981):

> " 'No lawful basis' . . . means that the insurer lacks a legitimate or arguable reason for failing to pay the claim. . . . 'Coupled with actual knowledge of that fact' implies conscious doing of wrong. Bad faith, then, is not simply bad judgment or negligence. It imports a dishonest purpose and means a breach of known duty, i.e., good faith and fair dealing, through some motive of self-interest or ill-will." Id., at 924.

and

> "The relevant question before the trier of fact would be whether a claim was properly investigated and whether the results of the investigation were subjected to a cognitive evaluation and review. *Implicit in that test is the conclusion that the knowledge or reckless disregard of the lack of a legitimate or reasonable basis may be inferred and imputed to an insurance company when there is a reckless indifference to facts or to proofs submitted by the insured."* Id. (Emphasis added.)

Did Aetna review the claim on four separate occasions, in good faith, considering all facts available to it and

according to its own established rules and procedures? To the contrary, the record is replete with evidence that at no time did Aetna review the claim in good faith, consider all the facts available to it and comply with its own established rules and procedures. It never obtained the hospital progress records or progress notes.

Brenda Harris, a senior claims processor in the Aetna Mobile office, with twelve years' experience in handling claims, was the first one to examine the Lavoie claim and, at the time, was primarily responsible for the claim within the Aetna Mobile office. She testified the denial of the claim was solely because of the reasons stated in the letter from Harris dated 3 June 1977.

Harris testified that Mrs. Lavoie's admitting diagnosis, ulcerative colitis, would have qualified her for coverage under the group medical policy that had been underwritten by Aetna, and the policy itself was in full force and effect at the time of Mrs. Lavoie's admission to the Mobile Infirmary.

Harris, on 5 April 1977, had sent some medical records to one Jean Becker, an Aetna senior claims examiner in Hartford, for review. They were identified by Dr. Bernard Swan, a member of Aetna's Home Office Medical Department, the only physician at Aetna who ever reviewed the Lavoie claim. He identified them as the admitting sheet, with diagnosis; medical history and physical; doctor's orders; discharge summary and certain extraneous information. The nurses' notes, which Dr. Swan stated were an integral part of the chart, were not supplied at that time. They were not obtained until April of 1978, a year later. Harris, at the Mobile office, acknowledged that the nurses' notes were not included in the information originally sent to the home office at the time of the first denial. She testified that significance of the nurses' notes was that they contained daily information on what was done to the patient,

what medications were administered, and whether a patient was experiencing pain or physical illness on a given date. Tom Hutton, an Aetna Home Office senior claims examiner at the time of his review of the Lavoie file in 1977, also testified he considered the nurses' notes to be a significant portion of any medical file, much more so from a physician's standpoint than a nurse's standpoint. The patient's progress notes were also omitted from the information sent to the home office during the first review of the Lavoie claim. Hutton also noted the significance of the patient's progress notes in a hospital file. Also, he said that, procedurally, had he seen certain of the entries that were actualy on Mrs. Lavoie's progress chart during this review of a claim he would, recognizing he is not medically qualified to make a decision as to whether a person's hospitalization would be reasonable in light of such information, first go through his Medical Department for a medical doctor's review before denying Lavoie's claim.

It should be noted there were a total of *four* reviews and four separate denials of the Lavoie claim *by the Aetna Home Office claims staff*. At *no time* did Aetna *ever* obtain Mrs. Lavoie's progress records and progress notes during its respective reviews and denials of the claim.

After submission of the Lavoie material to Aetna's Home office, it responded, on 27 April 1977 by directing its Mobile office to deny payment of the room and board charges and those charges for tests, including CAT scan (computer assisted tomogram), EEG (electroencephlgram) and an EKG (electrocardiogram), administered to Mrs. Lavoie during her hospitalization. The Home Office response stated the file had been reviewed with "a member of the Medical Department" and further that "on the basis of limited information submitted, this confinement does not appear to have been medically necessary. We feel this patient could have been evaluated and treated on an out patient basis." Payment of these charges was denied

because, allegedly, the tests were not "usual and customary for the diagnosis given."

According to the evidence, Aetna's Medical Department's alleged review was the primary reason for denial of the Lavoie claim. Aetna's Becker testified that, in her experience as a group claims representative in the field, the procedure for handling such group medical claims was to refer them to the senior claims examiner at the Home office, who in turn would refer the claim to the Medical Department.

Aetna's witness, Dr. Swan, testified he, as an associate medical director, worked in the claims department and reviewed complicated problems which required a medical opinion.

In the 27 April 1977 inter-office memo, Becker, the senior claims examiner in Hartford, speaks about review of the subject file "with a member of the Medical Department." She did not consider herself as being in the Medical Department. The reference to a member of the Medical Department is obviously a reference to Dr. Swan. This fact is shown by Dr. Swan's own testimony. Becker's testimony makes clear that her reference to the Medical Department was a reference to the doctor. Clearly, Hutton, the senior analyst in Hartford, according to Becker, was not a member of that Medical Department.

Dr. Swan testified the "Claim Medical Department" was comprised of six physicians. The testimony of Becker shows it was the customary procedure at Aetna for the various regional claims offices to refer claims to the senior examiners in the Home Office, who in turn referred the claims to the Medical Department for review.

The testimony of Harris acknowledges that her deposition testimony, in January 1980, made a clear distinction between Hutton, the senior claims examiner at the Home

Office, and the Home Office medical department. Harris, *in her trial testimony*, admitted that in her entire deposition she never stated Hutton and the Medical Department at Hartford meant one and the same thing to her.

The following appears during Harris's testimony:

> "Q: Do you recognize the medical department as being physicians, don't you?
>
> "A: I do now, yes, sir.
>
> "Q: No ma'am no. At the time you gave this deposition before you gave your affidavit, at the time you gave your deposition.
>
> "A: At the time I gave my deposition I did, yes, sir.
>
> "Q: O.K. and before you gave the affidavit, right?
>
> "A: Right."

However, in her affidavit of 28 February 1980, about thirty-five days after her deposition, filed in support of Aetna's motion for summary judgment, she swore:

> "I understand that an ambiguity may exist concerning my letter of December 23, 1977, to Thomas J. Stein. I stated in that letter that I had again checked with our Medical Department on this matter and they have advised that based on the information available to us, we must continue to deny benefits for the room and board."

In the same affidavit, Harris noted that she customarily referred to the senior claims examiner in Hartford as "our Medical Department."

On 4 November 1977, Dr. Douglas, Mrs. Lavoie's treating physician wrote a very detailed report to Thomas J. Stein, Mrs. Lavoie's attorney at the time. Dr. Douglas explained in detail why Mrs. Lavoie required a twenty-

three day period of confinement and why the tests, for which Aetna declined to pay, were relevant and necessary for her treatment at the time they were prescribed. Harris received the letter as an enclosure in a letter from attorney Stein to Aetna dated 8 November 1977. Harris called Hutton, the senior claims examiner at Hartford, on 9 November 1977. She testified she told Hutton she had additional information concerning the Lavoie file. She had no dealings with him on the Lavoie file before that time. She then read him the letter from the lawyer and from Dr. Douglas. After she read the doctor's letter to him Hutton instructed Harris to:

> "Maintain the denial. If they act like they are going to file suit, send it back to me."

Shortly thereafter she wrote Stein, continuing to deny the claim and implying a need for more information. On 19 December 1977, Stein again wrote Aetna, sending another report from Dr. Douglas that attempted to answer Aetna's questions regarding the treatment he rendered Mrs. Lavoie. The next day, 20 December 1977, Harris again called Hutton. Again, Hutton did not have a medical doctor on the telephone with him. She read Hutton the letter from Dr. Douglas. After the letter was read, Hutton directed her to continue denying the benefits based on the information available, and directed her to write the denial letter of 23 December 1977. In response to those directions from Hutton, Harris wrote to Stein:

> "I have again checked with our Medical Department on this matter, and they have advised that, based on the information available to us, we must continue to deny any benefits for the room and board."

That was in spite of two medical reports showing that hospitalization was necessary to rule out organic abdominal disease and also organic intracranial disease.

Harris and Hutton acknowledged that no medical doctor had ever reviewed either of the two medical reports that had been submitted to Aetna by the Lavoies.

Clearly, on two of the four separate and distinct denials of the Lavoie claim, Aetna violated all of its own recognized principles and procedures for handling such claims; by-passing the Medical Department that was the only source of medically qualified information available to Aetna and deliberately, intentionally and recklessly representing to the Lavoies that their file had been reviewed by a "member of the Medical Department."

Aetna's Dr. Swan told of the importance of having a member of the Medical Department, a physician, to pass judgment on complicated problems which require a medical opinion. Nevertheless, Harris wrote the Lavoie's attorney on 23 December 1977 stating she had "again checked" with the "Medical Department" regarding Dr. Douglas's letters. As a matter of fact, as of 23 December 1977, no member of the Medical Department had been consulted regarding Dr. Douglas's letters. She was fully aware of this when she wrote the 23 December 1977 letter to Stein.

The significance of Dr. Douglas's medical reports was noted by both Harris and Dr. Swan. Harris testified she recognized the importance of a treating physician's report to Aetna's Medical Department. She responded to questioning along this line as follows:

"Q: What is the importance of a doctor's report to the Medical Department?

"A: The Medical Department has to base their decision on what the doctor informs them.

"Q: And that's a hard and fast rule, isn't it?

"A: Yes, sir.

"Q: O.K., and the Medical Department has to review that doctor's report, isn't that right?

"A: Yes, sir.

"Q: No exceptions to that to your knowledge?

"A: Not to my knowledge.

"Q: You know that Mr. Hutton is not a medical doctor, don't you?

"A: Yes, sir.

"Q: Did you know it at the time that you called him on November 9, 1977?

"A: I knew that he was not a doctor, yes.

"Q: You knew that he was not a trained medical physician, correct?

"A: Yes, sir.

Dr. Swan's job at Aetna's Home Office Medical Department, he testified, was to "review complicated problems which require a medical opinion." He went on to volunteer the following under questioning by Aetna's own counsel:

"Q: Did you consider Dr. Douglas' letter?

"A: Yes. I was thumbing through it to try—I was interested in reviewing the letter, whether that's responsive to your question.

"Q: Yes, I was going to ask you. Did you pay attention to his letter? Did you read it?

"A: Yes, I did. I think the most important bit of information we like to get in such cases is a narrative report from the treating physician. It's the most logical source of information."

Another example of Aetna's intentional and fraudulent efforts to deceive the Lavoies was in connection with the initial handling and denial of the Lavoie claim. The initial request by the Mobile Office to the Hartford Group Claims office for a review of the Lavoie file was made on 5 April 1977. The Hartford Claims Office responded on 27 April 1977 with its initial denial. Becker recited that "this file has been reviewed with a member of the Medical Department." The evidence indicates that Dr. Swan, the only member of the Medical Department of Aetna who ever reviewed the Lavoie file, did not review the file material and records until 28 April 1977, one day *after* the original denial was sent to Mobile. Dr. Swan's own handwritten notes in the Home office file clearly show the first day he ever worked on the file was 28 April 1977. Dr. Swan worked in the Group Claims Office on only one day per week. 28 April 1977 was a Thursday. The date in Dr. Swan's own handwriting is "4-28-1977."

R. E. Mann, another Aetna senior claims processor who reviewed the file, noted that "[w]e reviewed *on 4/28/77* and denied coverage of some charges." Two to three months before the trial of this case and after it had been submitted to this court on appeal on two previous occasions where the critical nature of this particular date had become obvious, Becker, a senior claims examainer in Hartford, testified the "28" was a "25." Apparently, the jury didn't believe her.

Comparison of a "5" in Dr. Swan's handwriting found in the transcript with what Aetna contended was a "5" located elsewhere in the transcript makes it clear that Dr. Swan's review of the Lavoie file had been made on 28 April 1977, the day after the denial had been rendered by Ms. Becker.

Viewing this evidence most favorably to the Lavoies, the jury apparently rightfully concluded that senior claims

adjustors writing final denials and then later going to the medical staff for rubber stamp approval was all in violation of Aetna's own in-house procedure, which required that medical claims be denied by a medical doctor, and further that such was wilful and bad faith conduct. Dr. Swan's testimony clearly indicated he was contacted only on complex cases requiring a medical opinion. The denial had already been made on this "complex" case without any medical opinion whatsoever when the initial denial was made on 27 April 1977.

It is conclusive evidence that, at the time the first of the four denials was made of the Lavoies' claim, Aetna had *no legal justification for denial of the claim at all,* having established by its own testimony that a medical opinion is required in order to properly deny such a claim, and the evidence clearly and convincingly shows that such a medical opinion was *not obtained before the denial was made.*

A review of Mann's handwritten summary of the Home Office's fourth review of the Lavoie file, and comparison of it with Dr. Swan's testimony on this point reveals that absolutely *no* mention is ever made by Mann of any new consultation with a physician in the Aetna Medical Department on the basis of the newly submitted information, the nurses' notes. But, on 25 July 1978, Mann rendered his own opinion that the denial should be maintained. According to Dr. Swan, three days later, 28 July 1978, a Friday, is the first time he ever looked at the newly submitted nurses' notes on this particular review of the file. Dr. Swan's handwritten notes, made on this second review, clearly shows his review took place on 28 July 1978.

Mann's 7-25-78 handwritten review and his 28 July 1978 inter-office communication contain no reference to either of Dr. Douglas's reports generated in November and December of 1977.

Hutton did not consider himself, as a senior claims adjuster, qualified to render a medical opinion. "That's why we have our Medical Department," he testified. Further, that Dr. Swan was consulted on "complicated problems which *require* a medical opinion," Harris stated "the Medical Department has to base their decision on what the doctor informs them [in his doctor's report]." This was a hard and fast rule at Aetna, with no exceptions. A review of the documents generated at Aetna note the significance of, and the necessity for, the Medical Department's review. Virtually every document generated by the Claims Department states: "Our Home Office medical staff has again reviewed this claim."

There is a plethora of other places in the record of testimony and exhibits from which the only conclusion a reasonable person could draw is that Aetna, through its employees, was guilty of fraud, bad faith, and unfair dealing, had a dishonest purpose, and was motivated by self interest and ill will.

Clearly, then, under the evidence *in this case,* the "directed verdict on the contract claim" test is inapplicable because this is not the ordinary or normal case. *Safeco Ins. Co.* of *America* v. *Sims,* 435 So. 2d 1219 (Ala. 1983); *McLaughlin* v. *Alabama Farm Bureau Mut. Cas. Ins. Co.,* 437 So. 2d 86 (Ala. 1983).

In order to fully comprehend the "extraordinary nature of this case, it is first necessary to review the policy considerations, elements, and instructive guide posts set out by this court in earlier case law.

This court first recognized an actionable tort for an insurer's intentional refusal to pay a direct claim in *Chavers* v. *National Security Fire & Casualty Co.,* 405 So. 2d 1 (Ala. 1981). Such a claim arises where there is either:

> "'(1) no lawful basis for the refusal coupled with actual knowledge of that fact or (2) intentional failure

> to determine whether or not there was any lawful basis for such refusal.' "

The policy considerations inherent in this cause of action are that the law cannot tolerate, nor will it allow, the willful, deliberate refusal on the part of the insurer to evaluate or honor a claim with the knowledge that the avowed purpose of the insurance contract was to protect the insured at his weakest and most perilous time of need. *Vincent* v. *Blue Cross-Blue Shield of Alabama,* 373 So. 2d 1054, 1067 (Ala. 1979) (Embry, J., dissenting).

As noted above, *Gulf Atlantic Life Insurance Co.* v. *Barnes,* 405 So. 2d 916 (Ala. 1981), defined the second tier of the tort of bad faith as set out in *Chavers.* Justice Beatty's instructive voice is particularly applicable here and bears repeating:

> "The relevant question before the trier of fact would be whether a claim was properly investigated and whether the results of the investigation were subjected to a cognitive evaluation and review. Implicit in that test is the conclusion that the knowledge or reckless disregard of the lack of a legitimate or reasonable basis may be inferred and imputed to an insurance company when there is a *reckless indifference to facts or to proof submitted by the insured* . . . ." (Emphasis added.)

Gulf Atlantic Life Insurance Co., 405 So. 2d at 924.

Gulf Atlantic's instructions evidence this court's initial concern that the existence *vel non* of bad faith must be measured not in a vacuum, but under the circumstances, and *at the time that the insurer denied the claim.* Accordingly, where an insured relies upon the second tier of bad faith, as in this case, the insurer's reckless indifference to facts or to proofs submitted by the insured must be measured *at the time of the denial.*

National Security Fire & Casualty Co. v. *Bowen,* 417 So. 2d 179 (Ala. 1982), reiterated the elements of a bad faith action:

> "(a) an insurance contract between the parties and a breach thereof by the defendant;
>
> "(b) an intentional refusal to pay the insured's claim;
>
> "(c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);
>
> "(d) the insured's actual knowledge of the absence of any legitimate or arguable reason;
>
> "(e) if the intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim." *Id.,* at 183.

In determining that sufficient evidence was not produced which eliminated any "arguable reason" for National Security's refusal to pay plaintiff's claim, this court focused entirely upon an investigator's report, which was reviewed by National Security, and the concomitant circumstances. In fact, the court unambiguously declared:

> "[T]hese principles cause us to inquire into the evidence establishing the reasons which prompted Rufus D. Johnson to recommend not paying Bowen the balance due under the policy. In exploring those reasons *we must consider the information before Johnson at the time he made the decision not to pay Bowen.*" *Id.*

On still two more occasions this court has reiterated this most important factor in determining the existence *vel non* of bad faith.

> "Whether an insurance company is justified in denying a claim under a policy must be judged by what was before it at the time the decision is made . . . ." *National Savings Life Insurance Co.* v. *Dutton,* 419 So. 2d 1357, 1362 (Ala. 1982); *Federated Guaranty Life Insurance Co.* v. *Wilkins,* 435 So. 2d 10 (Ala. 1983).

The obvious reason for reviewing only the information and circumstances before the insurer at the time of the denial, is to view the conduct of the insurer within the factual framework existing at the time of its actions. To adjudge the existence *vel non* of fad faith in any other environment would be merely an exercise in judicial fiction.

Aetna insists that the conflicting testimony developed at trial concerning the reasonableness and necessity of the treatment rendered Mrs. Lavoie constitutes a genuine issue of whether the insurance contract benefits were due and owing to her. In light of such a disputed issue on the contract claim, Aetna argues, the plaintiffs were not entitled to a directed verdict on the contract claim at the close of the evidence. Citing *National Savings Life Insurance Co.* v. *Dutton,* 419 So. 2d 1357 (Ala. 1982), Aetna concludes that since a directed verdict on the contract claim was inappropriate, the Lavoies' bad faith claim should never have been submitted to the jury.

Two of five physicians testifying at trial stated that Aetna's actions in denying the claim were reasonable because the charges in question were not shown to be medically "necessary for the treatment of the injury or disease concerned;" the language contained in the policy exclusion. Nevertheless, Aetna's argument is critically defective in that *at the time of each successive denial Aetna had never once consulted any medical authority.* That Aetna is now capable of creating a fact issue on the contract claim through expert testimony does not, and cannot, belie the fact that Aetna never sought medical consultation, nor

reviewed the treating physician's detailed medical reports, nor reviewed any progress notes before denying an admittedly complicated medical claim. A thousand experts testifying retrospectively could not avert the fact that, without a doubt, Aetna recklessly disregarded the facts and proofs of claim submitted by the Lavoies. *Gulf Atlantic Insurance Co.,* 405 So. 2d at 924.

Herein lies the "extraordinary" nature of this case. In the face of such overwhelming evidence, reasonable men could not disagree, that Aetna was guilty of bad faith, ill-will, oppression and malice in their successive refusals of the Lavoie claim. However, Aetna, through evidence of its own creation, is now capable of raising a factual dispute over the contract claim. To allow Aetna to wholly evade liability through legal artifice under the circumstances of this case would be to reward it for the very conduct which the tort of bad faith was originally recognized to admonish. At some point, some one must declare, "The emperor has no clothes." We take that opportunity today.

Aetna incorrectly reads the case of *National Savings Life Insurance Co.* v. *Dutton,* 419 So. 2d 1357 (Ala. 1982), as requring an application of the directed verdict test in every bad faith case. We do not read *Dutton* in such a restrictive fashion. This court stated in *Dutton:*

> "In the *normal* case in order for a plaintiff to make out a prima facie case of bad faith refusal to pay an insurance claim, the proof offered must show that the plaintiff is entitled to a directed verdict on the claim and, thus, entitled to recover on the contract claim as a matter of law. *Ordinarily, if the evidence produced,* by either side *creates a fact issue* with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail and should not be submitted to the jury." (Emphasis added.) *Id.* at 1362.

First of all, nothing in this critical proposition was intended to retract or modify the fundamental concept that an insurance company's bad faith is adjudged by what was before it at the time the decision to deny the claim was made. In fact, this very principle is clearly set out, as well as applied, in *Dutton.* See *Dutton,* 419 So. 2d at 1362. This court found that hospital records, *relied upon by the insurer* in denying Mrs. Dutton's claims, indicated that she had suffered chest pains for two or three years. This was in direct contradiction to Dutton's insurance application, another document relied upon by the insured at the time of the denial.

Second, Aetna has ignored the qualifications placed on the directed verdict test noted above. In his concurring opinion, Justice Jones noted:

> "These are significant qualifications. Certainly, extreme cases will arise in which a fact issue will present a jury question on that claim . . . ." *Id.,* at 1362-63.

This is such an extreme case.

Furthermore, in *Safeco Insurance Co. of America* v. *Sims,* 435 So. 2d 1219 (Ala. 1983), this court held:

> "We are of the opinion that the finding of justiciable controversy is not the determining factor of whether there was or was not bad faith on the part of an insurance company to pay a claim. The standard for testing a bad faith claim is not found in either the adjudication of a justiciable controversy or the *judgment on the merits of the contract claim.* (Emphasis added.) *Id.,* at 1223.

Again, Justice Jones, in his special concurring opinion, amplified the meaning of the majority's quoted language.

> "The standard for testing a bad faith claim is to be found neither in the adjudication of a justiciable con-

> troversy, standing alone, *nor in the judgment on the merits of the contract claim.* This is not to say, of course, that either of these holdings is irrelevant to the bad faith issue. To be sure, the filing of a declaratory judgment action, under appropriate circumstances, may evidence a good faith attempt to seek a prompt resolution of a disputed claim. *If, on the other hand, the refusal to pay is without legal excuse, the mere filing of a declaratory judgment action, followed by a finding of justiciable controversy, may enhance rather than diminish the degree of bad faith.*" (Emphasis added.) *Id.* at 1224.

In commenting directly upon the *Dutton* case, Justice Jones stated:

> "This 'directed verdict on the contract claim' test is not to be read as requiring, in every case and under all circumstances, that the tort claim be barred unless the trial court has literally granted plaintiff's motion for a directed verdict on the contract . . . . Merely because the insurer may be able to withstand a directed verdict motion—the existence *vel non* of the record entry itself being an issue of fact—would not, as a matter of law, bar the plaintiff's tort claim . . . ." *Id.*, at 1225.

A hypothetical raised by the Lavoies illuminates the legal inconsistencies and inequitable consequences which would surely arise should the court adopt, as Aetna suggests, an unyielding, universal application of the directed verdict test. We now offer that hypothetical in a modified form. Assume that an insured submits a valid medical claim to an insurance company in the amount of $20,000. Although the company knew it was contractually obligated to pay the claim, it nevertheless, with malicious and oppressive intentions, decided to deny $15,000 of the claim. In order

to accomplish this, assume that ten employees of the insurance company's medical staff and claims department confederated to create a totally false and absolutely unsubstantiated reason for denying the claim. As litigation over the nonpayment ensued, assume that all ten employees "stuck to their story" in their depositions. At trial however, suppose that nine of the ten employees broke down on the stand, admitting they had lied in deposition, and further agreeing with the plaintiff's contentions that they had indeed engaged in a conspiracy to deprive the plaintiff of his contractual benefits. Nevertheless, assume that the one lone claims superintendent insisted the company had based its denial on a fairly debatable aspect of the insured's claim. Under such a scenario, in light of the scintilla rule, a directed verdict on the contract claim would be inappropriate. Accordingly, under blind adherence to a directed verdict standard, as Aetna recommends, the bad faith claim would never go to the jury.

Such simply cannot be the law. The tort of bad faith had as its genesis the very idea of providing a plaintiff who had been victimized by the intentional, wrongful handling of a claim by the insurer, the right to recover not only contract damages but for the loss occasioned by emotional suffering, humiliation, and embarrassment in addition to punitive damages. The plaintiff's right to recover for the malicious and oppressive denial of a valid insurance claim must not be allowed to rest precariously upon the insurer's ability to *retrospectively* create an issue of fact on the contract claim. As Justice Jones adeptly foresaw and forewarned.

> "The mere filing of a declaratory judgment action, followed by a finding of a justiciable controversy, may enhance rather than diminish the degree of bad faith." *Safeco Insurance Co.*, 435 So. 2d at 1224.

Our findings today, in this narrow context, are likewise consistent with the recent decision of *National Security Fire & Casualty Co.* v. *Vintson,* 454 So. 2d 942 (Ala. 1984). In *Vintson,* this court, citing *National Savings Life Insurance Co.* v. *Dutton, supra,* applied the directed verdict test in determining that the plaintiff's bad faith claim was improperly submitted to the jury. The critical facts presented by that case, however, are clearly distinguishable.

In *Vintson,* the plaintiff alleged that a National Security agent, in an effort to induce the plaintiff to buy fire insurance, represented that the plaintiff's mobile home would be covered from the moment he submitted his application and premium check to the insurance company. Vintson submitted his application and check to the National Security agent who forwarded it to the home office for processing. Shortly thereafter, Vintson's mobile home burned.

At trial, National Security's agent denied making the alleged representations to the plaintiff regarding the time coverage would commence. Consequently, a fact issue concerning the *existence* of the contract itself was created.

Furthermore, evidence presented at trial proved that at the time National Security denied the claim, it had before it the standard application for insurance and that until an application for insurance was approved by the company, and the policy was issued and delivered, no policy of insurance was binding. We concluded that the above facts in and of themselves satisfied the requirement of a debatable reason thereby precluding submission of the bad faith claim to the jury.

In stark contrast to the facts in *Vinston,* here the *existence* of an insurance contract is undisputed. Thus, in addition to all the rights an obligations set out by the contract itself, arises the duty, *implied by law,* to use good faith and fair dealing so as to not interfere with the other party's expectation of performance. *Chavers* v. *National*

Security Fire and Casualty Co., 405 So. 2d 1, 6 (Ala. 1981). See also *Vincent* v. *Blue Cross-Blue Shield of Alabama*, 373 So. 2d 1054, 1060 (Ala. 1979) (Jones, J., concurring specially).

Did Aetna breach this duty in denying the Lavoie claim? The inescapable answer is, yes. As distinguished from the situation in *Vintson*, Aetna failed to follow its own in-house procedures in denying the claim. This court found a debatable reason existed in *Vintson* based upon what was before National Security at the time of the denial and in light of the existing circumstances; specifically a mere *application* for insurance and an in house requirement that an application be approved, a policy issued, and a policy delivered, before coverage was extended. In contrast, it is undisputed that Aetna had before it a complicated medical claim and an in-house requirement that all complicated medical claims be reviewed by the medical department. This it failed to do on four successive occasions.

Moreover, in *Vintson*, as well as in *Dutton*, this court found that based upon what was before the insurance company at the time of the denial, the insurer had no duty to investigate the claim further. In *Dutton*, the insurance company in denying the claim invited the insurer to submit additional medical information. This was not done. A similar invitation was extended by Aetna in this case. Mrs. Lavoie responded on two separate occasions by having her treating physician write Aetna and outline the necessity of her hospital confinement. Aetna, upon receiving this requested information, did nothing. In our view, this is precisely the "reckless indifference to the facts and proofs submitted" which *Gulf Atlantic Life Insurance Co.* v. *Barnes, supra*, originally delineated as reprehensible conduct, in breach of the duty of good faith and fair dealing.

Accordingly, we hold that under the "extraordinary" facts of this case, the bad faith claim was properly submitted to the jury.

II

The second issue raised by the appellant concerns whether Aetna's partial payment of the Lavoie claim, by law, precludes a finding of bad faith refusal to pay. Aetna argues that its payment of some $1,300 of the $3,000 Mobile Infirmary bill constitutes a complete defense to the tort of bad faith. In support of this argument, Aetna relies principally upon *Sexton* v. *Liberty National Life Insurance Co.*, 405 So. 2d 18 (Ala. 1981).

In *Sexton,* this court upheld a summary judgment entered in favor of the defendant, Liberty National Life Insurance Company, on the bad faith refusal to pay count. In doing so, this court noted that the record was wholly devoid of any evidence even tending to show an intentional failure to honor a meritorious claim on the part of the insurer. In reference to the alleged refusal we stated:

> "Having paid a substantial part of the claim, the failure to pay another part could well have been a clerical error . . . ." *Id.*, at 22.

This statement merely highlights the lack of evidence supporting bad faith proffered in *Sexton* and further emphasizes the proposition that a plaintiff must show more than a mere nonpayment, but a bad faith nonpayment. *National Security Fire and Casualty Co.* v. *Bowen,* 417 So. 2d 179, 183 (Ala. 1982). Neither the language cited above, nor any other language in *Sexton* reaches the proposition, gleaned by the appellants, that a partial payment of an insurance claim establishes an absolute defense to a bad faith refusal to pay action.

Likewise, a partial payment and a full payment were respectively considered in *National Security Fire and Casualty Co.* v. *Bowen, supra,* and *Cincinnati Insurance Co.* v. *Little,* 443 So. 2d 9891 (Ala. 1983). In each instance, this court held that bad faith claims were improperly sub-

mitted to the jury in light of the absence of any evidence proving a refusal based on bad faith. While it is true that partial payments may be considered as evidence of a lack of a dishonest purpose or ill-will in an insurer's denial, it does not follow that partial payment, in and of itself, precludes recovery under a bad faith theory. Otherwise, an insurer could avert liability in tort even though the evidence conclusively proved that the insured was the victim of an intentional denial of a portion of a claim which was not otherwise reasonably debatable. In fact, situations may be envisioned where a partial payment is made solely for the purpose of disguising the intentional, oppressive, malicious denial of the remainder of a claim. Under such a scenario the existence of bad faith would be enhanced, rather than diminished.

Under the facts of this case, any inference of the lack of a dishonest purpose afforded Aetna, due to its partial payment, has been crushed beneath the overwhelming weight of evidence proving that Aetna's dealings with the Lavoie claim on four occasions were infected with conspiracy and deceit. Accordingly, the bad faith claim was properly submitted to the jury despite the existence of partial payments made by Aetna.

III

We now turn to whether the jury verdict of $3,501,650.22 is so excessive that it must be set aside.

Gulf Atlantic Life Insurance Co. v. *Barnes,* 405 So. 2d 916 (Ala. 1981), announced that punitive damages were recoverable under the tort of bad faith. In distinguishing between the bad faith conduct which gives rise to compensatory damages as opposed to punitive damages, this court noted:

> " 'It does not follow that because plaintiff is entitled to compensatory damages that he is also entitled

> to exemplary damages. In order to justify an award of exemplary damages, the defendant must be guilty of oppression, fraud or malice . . . . While we have concluded that defendant violated its duty of good faith and fair dealing, this alone does not necessarily establish that defendant acted with the requisite intent to injure the plaintiff.' . . ." 405 So. 2d at 925 (quoting *Silberg* v. *California Life Insurance Co.*, 11 Cal. 3d 452, 113 Cal. Rptr. 711, 521 P. 2d 1103 (1974).

The purpose behind the imposition of punitive damages is twofold: (1) to punish the defendant for his oppressive, willful acts *and* (2) to warn or deter others in similar businesses from equally reprehensible conduct. *Badgett* v. *McDonald*, 53 Ala. App. 726, 728, 304 So. 2d 228 (Ala. Civ. App. 1974). The imposition of punitive damages in a fraud case is discretionary with regard to both the enormity of wrong and the necessity of preventing similar wrongs. *Ford Motor Credit Co.* v. *Washington*, 420 So. 2d 14, 17 (Ala. 1982). *Carlisle* v. *Miller*, 275 Ala. 440, 155 So. 2d 689 (1963), echoed the guiding rules of review where any jury verdict is challenged as being excessive:

> "It is most platitudinous to restate the guiding rules, but here they are: the verdict of a jury should not be interfered with merely because in the opinion of the court the jury gave too little or too much . . . and the *authority vested in the courts to disturb a verdict of the jury on the ground of excessiveness is one which should be exercised with great caution.* . . . Where, as here, there is no set standard for the admeasurement of damages but the damages to be awarded are left to the sound discretion of the jury, a remittitur or a new trial should not be ordered on the ground of excessiveness of the jury verdict except in those cases where the court can clearly see that the verdict has been reached on account of bias, passion,

> prejudice, corruption or other improper motive or cause . . . and only where the damages allowed are so excessive as to warrant the belief that the jury must have been misled by some mistaken view of the merits of the case should the court interfere and set the verdict aside . . . *also, where the trial court refuses to grant a new trial because he does not believe the verdict is excessive the favorable presumption attending the jury's verdict is thereby strengthened.*" (Citations omitted.) (Emphasis added.) (Cited with approval in *Aspinwall* v. *Gowens*, 405 So. 2d 134 (Ala. 1981).)

After a careful review of the entire record, we cannot conclude that the verdict is so excessive as to warrant a finding that it was based upon bias, passion, prejudice or some other improper motive. The plaintiffs were able to show that the dark shadows of fraud and conspiracy enveloped each and every aspect of Aetna's actions regarding the handling of the Lavoie claim from the instance of the first denial and continued throughout the trial itself.

The evidence presented to the jury justifying such a large verdict may be analyzed in two categories: First, a recitation of the successive denials of the Lavoie claim which grew out of Aetna's oppressive, malicious, willful, fraudulent disregard for the rights of Mrs. Lavoie, and from which a jury could not only impute an intent to injure, but could hardly ignore it; second, an open court demonstration of fraud on the part of Aetna in an effort to evade liability at any cost.

The details of the Lavoie denials have been adequately set out in the foregoing portions of this opinion. Let it suffice to say, however, that the evidence of record supports the following findings:

> (1) Aetna took the position that a woman who was bleeding bright red blood from the rectum, had flight of ideation, was acutely ill, and demonstrated person-

ality changes, should have been treated as an outpatient.

(2) Aetna make its initial denial of the subject claim without any legal justification, and with no medical opinion to support the denial of a complicated medical treatment claim.

(3) Aetna made a second denial without any medical decision whatsoever, in violation of the established company procedure for handling such claims.

(4) Upon receiving medical letters detailing the need for hospital confinement and letter of inquiry from Lavoie's attorney, Aetna decided to wait to see if the Lavoies were going to file suit.

(5) Aetna made a third denial of the claim without any medically qualified opinion to support the denial, again in violation of the company's established procedures.

(6) Aetna intentionally misrepresented to the Lavoies that the claim had been repeatedly reviewed by members of the medical department.

(7) Aetna never had the "most important medical information" available on this file reviewed by any medical doctor during the course of the four denials.

Plaintiffs were successful in unveiling an effort on the part of Aetna to cover-up its wrongdoing. In effect, the jury witnessed an open court demonstration of the type of fraud which Aetna denied so vehemently.

A senior claims processor for Aetna, Brenda Harris, acknowledged at trial, that her deposition testimony of January 1980 unequivocally drew a distinction between Tom Hutton, the senior claims examiner at the home office, and the "Home Office Medical Department." Ms. Harris

admitted at trial that not one time in her deposition did she ever tell plaintiff's counsel that Tom Hutton and the Medical Department were one and the same thing to her.

Nevertheless, plaintiffs read into evidence the sworn affidavit of Ms. Harris, filed by Aetna in support of its initial motion for summary judgment some 35 days after Harris's deposition, which is in direct contradiction to Harris's deposition testimony.

The affidavit reads in part:

> "I understand that an ambiguity may exist concerning my letter of December 23, 1977, to Thomas J. Stein. I stated in that letter that I had again checked with our Medical Department on this matter and they have advised that based on the information available to us, we must continue to deny benefits for the room and board."

Thereafter, in the same affidavit, Ms. Harris notes that she "customarily" refers to the senior claims examiner in Hartford as our "Medical Department."

The jury could have rightfully concluded, and apparently did, that Ms. Harris's affidavit was nothing more than an attempt to cover-up, through deceit, past frauds committed in handling the Lavoie claim.

Likewise, Dr. Swan testified at trial that although he had reviewed "the letter" from Dr. Douglas, it did not contain information warranting a change in the recommendation to deny the claim. Plaintiff's counsel produced an affidavit signed by Dr. Swan, however, indicating that Dr. Swan had never once reviewed any letter from Dr. Douglas.

Lastly, Tom Hutton, a senior claims examiner, originally testified at trial that he had never reviewed the Lavoie file after 20 December 1977; this included the period of time

when the nurses' notes were submitted and when the last claims denial occurred.

On cross-examination, Mr. Hutton was confronted with his sworn testimony in an earlier deposition. In that deposition, Mr. Hutton testified that he reviewed the file in 1978, discussed the review with Dr. Swan, reviewed the nurses' notes, and submitted Dr. Douglas' letters to Dr. Swan. All of the above would have been impossible, if in fact, as Hutton testified, he never reviewed the Lavoie file after 20 December 1977.

We note additionally that the trial judge denied Aetna's motion for a new trial or in the alternative, a remittitur, based on the excessiveness of the verdict. As the trial judge is in a position to judge both the demeanor of the witnesses and jurors, his denial of Aetna's motion must naturally strengthen the jury verdict.

Based upon the foregoing, we cannot conclude the verdict was a result of bias, passion, prejudice, or some other improper motive. Accordingly, it is our duty to leave it undisturbed.

IV

The final argument raised by the appellant concerns whether testimony regarding the Lavoies' financial condition was impermissibly allowed into evidence.

Aetna argues the following questions were not relevant and that their admisison served only to raise the passion and bias of the jury:

> "Q: What was your total family income, you and your wife from Social Security and your disability and your wife's disability in February of 1977?
>
> "MR. CUNNINGHAM: Your Honor, that's not relevant at all. As to what his income is has nothing to do with the material involved in this lawsuit.

"MR. CROWDER: Your Honor, it's very relevant.

"THE COURT: Overrule the objection."

Mr. Lavoie went on to testify that his total income for that month was $700. On a second occasion Mr. Lavoie was asked:

"Q: Well, Mr. Lavoie, why didn't you just go ahead and pay the bill from the Infirmary and wait and see how the outcome of this would be?

"A: Because I didn't have the money."

The test of relevancy applied in Alabama is whether the offered evidence bears any logical relationship to the ultimate inference for which it is offered. C. Gamble, *McElroy's Alabama Evidence* § 21.01 (3d ed. 1977). The inference for which the evidence is offered, of course, must be material to an issue in the case. *Ex parte Killough*, 438 So. 2d 333, 335 (Ala. 1983).

In the case at hand, plaintiffs may properly recover compensatory changes for economic loss and mental distress. *Gulf Atlantic Life Insurance Co.* v. *Barnes*, 405 So. 2d 916, 925 (Ala. 1981); *Chavers* v. *National Security Fire & Casualty Co.*, 405 So. 2d 7 (Ala. 1981). In support of their theory of recovery, the plaintiffs offered proof that the bad faith refusal to pay the amount due for medical care to the Mobile Infirmary resulted in the plaintiffs' receiving collection letters and threats of suit from the Mobile Infirmary, a collection agency, and an attorney. All of this contributed to and caused the plaintiffs to suffer extreme emotional distress.

It is axiomatic that the law imposes a duty upon all plaintiffs to mitigate their damages. *Britton* v. *Doehring*, 286 Ala. 498, 507, 242 So. 2d 666 (1970). We find the evidence in question to be admissible in order to show that the Lavoies were incapable of paying the Mobile Infirmary

bill with their own finances, and thereby reducing the emotional distress caused by hounding creditors.

Accordingly, there appearing no error in the record, the judgment of the trial court is due to be, and it is hereby, affirmed.

AFFIRMED.

Faulkner, Jones, Almon, Embry and Adams, JJ., concur.

Torbert, C. J., Maddox, Shores and Beatty, JJ., dissent.

TORBERT, CHIEF JUSTICE (dissenting).

The tort of bad faith breach of an insurance contract was judicially created to fill a remedial void. Had it not been for the lack of adequate contractual damages, the need for this tort in the insurance context (and it thus far has been restricted to insurance in Alabama) would not have arisen. Traditionally, contract damages for breach of an insurance policy were limited by the classic case of *Hadley v. Baxendale,* 9 Ex. 341, 156 Eng. Rep. 145 (1854), to the face value of the insurance policy plus the legal rate of interest. Consequential damages for personal injuries, inconvenience, annoyance, loss of job or business, or mental anguish and suffering were not recoverable *ex contractu,* such damages being viewed as unforeseeable and not within the contemplation of both parties at the time of contract formation. This rule excluding consequential damages is still followed in non-insurance contexts in Alabama today. See, *Jefferson County Burial Society v. Curry,* 237 Ala. 548, 187 So. 123 (1939); *Stead v. Blue Cross-Blue Shield of Alabama,* 346 So. 2d 1140 (Ala. 1977). Of course, punitive damages are disallowed, as well.

In severely limiting contractual damages to the face value of the policy plus the legal rate of interest, the law created an incentive for insurers to refuse payment of even legitimate claims. The insurers had nothing to lose, and

everything to gain, by refusing payment of even meritorious claims. At most, the assessed damages would equal the limits of the policy plus the legal rate of interest (sometimes far below the actual market rate). Any tangible consequential economic damages, such as loss of job or bankruptcy, and intangible damages, such as emotional distress, were borne entirely by the insured, on the basis that certainly they were not within the contemplation of the bargain of the parties. Consequential losses were allowed to lie where they fell, even in the case of intentional breach of contract.

If I were writing on a clean slate, yet enlightened by foreseeing the results of this Court's recognition of the tort of bad faith, I would be inclined to argue for an expansion of the damage rules in contract rather than creation of a new tort. There are several advantages to confining first-party insurance cases to the field of contract law, with an expansion of the damages remedy.

Contractual duties are consensual, and even when implied they have the virtue of implication from the contract itself. There are well-established rules for determining a breach and its consequences. Contracts is perhaps the most concrete and predictable body of legal doctrine, whose application is unlikely to defeat any valid expectation interests of the parties; this is certainly important in the insurance context, where predictability, at least of the statistical variety, is necessary in calculating premiums. Finally, judicial control of the excesses of passionate juries is less problematic in contracts than it is in the realm of torts. In contracts, the important issues are more often legal than factual, and any modification of damage rules would not require the availability of punitive damages.

In contrast to the virtues of contract law in general, and to a mere modification of contract damage rules in particular, the creation of any new tort is fraught with dis-

advantages, as our recent experience with the insurance-specific tort of bad faith demonstrates.

The duties recognized in tort are non-consensual, imposed from without, either because of a special relationship between the parties or because of perceived public policy implications. Such duties are of necessity amorphous, becoming in application little more than matters of degree, best suited to resolution by a jury. Tort duties are difficult to judicially define or confine; although most courts are content with the enuciation of standards, such as "reasonable care," in defining tort duties, wherever courts enunciate particular concrete rules, the process becomes endless, with attempts to cover each fact situation specifically as it arises, ultimately causing more confusion than clarity as the specific rules inevitably conflict.

Determining whether the breach of a tort duty has occurred is almost as problematic and fluid as is the initial definition of the duty. Unlike contracts, the comparative advantage in making this determination lies with the jury, and not the judge. Because tort cases are so fact-intensive and the liability rules so amorphous, the results at trial are unpredictable and often inconsistent, an especially undesirable consequence in the insurance context. Finally, in tort the scope of liability is much broader than in contract, especially with respect to intentional torts. Almost all damages proximately flowing from the cause are recoverable; and, of course, punitive damages are recoverable in the appropriate aggravating circumstances. This problem of excessive and even spurious damage awards could have been, and still can be, obviated by simply restricting the cause of action to contract and carefully expanding the contractual damages rules for non-commercial insurance contracts.

The foundation for such a carefully crafted expansion has already been laid in Alabama law. As already noted in

Stead, supra, consequential damages have been viewed unfavorably in Alabama in recent years in breach of insurance contract cases, due to the fact that they were "too remote, were not within the contemplation of the parties, and [the fact] that the breach of contract is not such as will naturally cause mental anguish." *Stead, supra,* at 1143, citing *Westesen v. Olathe State Bank,* 78 Colo. 217, 240 P. 689 (1923).

Yet, certain exceptions to this general rule have long been recognized in Alabama and around the country. As quoted in *Southern Ry Co. v. Rowe,* 198 Ala. 353, 73 So. 634 (1915), and repeated in *Stead, supra,* at 1143, ". . . where the contractual duty or obligation is so coupled with matters of mental concern or solicitude, or with the feelings of the party to whom the duty is owed, that a breach of the duty will necessarily or reasonably result in mental anguish or suffering, it is just that damages therefore be taken into consideration and awarded."

Certainly an insurance contract is not an ordinary commercial contract for profit in which mental distress damages are unforeseeable. The insured does not bargain for a profit; instead he bargains for compensation in time of catastrophe and for peace of mind. In this sense, an insurance contract is more akin to contracts of carriers and innkeepers, for which consequential damages have long been recognized due to the personal nature of the service. A particularly likely risk of breaching an insurance contract is resulting impoverishment or bankruptcy. Coupled with the fact that such breaches almost always coincide with emotional vulnerability (death, health problems, or destruction of a business or home), a very strong case can be made for awarding consequential damages for financial loss and even for emotional disturbance. See, *Restatement (Second) of Contracts,* § 353, comment a (1982). Insurers, in effect, sell freedom from care and worry, and should be held to foresee the consequential damages flowing from

their breach. Several cases in other jurisdictions have flirted with this approach. See, *Reichert v. General Ins. Co. of America,* 68 Cal. 2d 822, 849, 69 Cal. Rptr. 321, 337 (1968) (dissenting opinion); *Miholevich v. Mid-West Mut. Auto. Ins. Co.,* 261 Mich. 495, 246 N.W. 202 (1933); see also, K. Harvey and T. Wiseman, *First Party Bad Faith: Common Law Remedies and a Proposed Legislative Solution,* 72 Ky. L.J. 141 (1983-84).

Alabama courts have recognized that contracts dealing with new home construction are a special category, falling within the exception to the general damages rule, allowing recovery for mental anguish and annoyance and inconvenience, as well as other consequential damages deemed foreseeable. *B & M Homes, Inc. v. Hogan,* 376 So. 2d 667, 671 (Ala. 1979). The case is even stronger for creating such an exception for insurance conracts. Consequently, recent cases denying such damages for breach of insurance contracts should be overruled. See *Sanford v. Western Life Ins. Co.,* 368 So. 2d 260 (Ala. 1979); *National Sec. Fire & Cas. Co., Inc. v. Vintson,* 414 So. 2d 49 (Ala. 1982) (consequential damages denied).

By making it attractive to sue alternatively, or even exclusively, in contract, this Court could have avoided many of the problems associated with developing a new tort. As an added benefit, much of the appellate workload would be reduced in reviewing excessive jury awards of punitive damages, since punitive damages are not available in contract.

The whole question of bad faith by insurance companies might be an issue more properly addressed by the legislature. The existing regulation of the insurance industries is a public-policy recognition by this state that consumers need some protection in this field. A proper balance between the two competing policy objectives inherent in claims of first-party bad faith must be struck.

> "The first objective recognizes that an insured's cause of action for first party bad faith should entitle him to damages promised under the policy, and consequential damages 'within the contemplation of the parties.' The second public policy implicated by first party bad faith is that the risks of excessive judgments should not be so unreasonable that they discourage insurers from challenging claims that are at least fairly debatable. Any effective resolution of the problem must address these two policy goals.
>
> "The difficult questions raised by first party bad faith require a careful balancing of the competing interest. Unfortunately, the courts, restrained by principles of common law formulated to solve different problems, have found it difficult, and sometimes impossible, to achieve a workable balance. . . . Because of the failure of the common law to provide an effective resolution, a legislative solution is appropriate. The legislative forum can provide for the consideration and debate of all viewpoints, resulting in a proper balance."

K. Harvey and T. Wiseman, *supra,* at 190 (see also the statute proposed by the authors in the appendix at p. 195).

However, this is all water under the bridge for now, so we must struggle to manage what has come to be the unmanageable.

Chavers I established that there was a duty to use good faith and fair dealing so as to not to interfere with the other party's expectation of performance in an insurance contract. *Chavers v. National Security Fire and Casualty Co.,* 405 So. 2d 1 (Ala. 1981). An insurer will breach that duty if it intentionally refuses to settle a direct claim where there is either no lawful basis for the refusal, coupled with actual knowledge of that fact, or intentional failure to determine whether or not there was any lawful basis for such refusal. *Id.* at 7.

In the cases since *Chavers I* we have attempted to refine and clarify the *Chavers I* test. In *Gulf Atlantic Life Insurance Co. v. Barnes,* 405 So. 2d 916 (Ala. 1981), this Court said:

> "The first tier of the test promulgated by Mr. Justice Embry and adopted by this Court in *Chavers* establishes that the tort of bad faith refusal to honor a direct claim arises when there exists 'no lawful basis for the refusal coupled with actual knowledge of that fact.' 'No lawful basis,' as expressed in that opinion, means that the insurer lacks a legitimate or arguable reason for failing to pay the claim. See *Michael v. National Security Fire & Casualty Co.,* 458 F.Supp. 128 (N.D. Miss. 1978). That is, when the claim is not fairly debatable, refusal to pay will be bad faith and, under appropriate facts, give rise to an action for tortious refusal to honor the claim. *Anderson v. Continental Insurance Co.,* 85 Wis. 2d 675, 271 N.W.2d 368 (1978). When a claim is 'fairly debatable,' the insurer is entitled to debate it, whether the debate concerns a matter of fact or law. 'Coupled with actual knowledge of that fact' implies conscious doing of wrong. Bad faith, then, is not simply bad judgment or negligence. It imports a dishonest purpose and means a breach of known duty, [*i.*]*e.,* good faith and fair dealing, through some motive of self-interest or ill will.
>
> "The second tier of the test is an elaboration on the first. The trier of fact, by finding, on the part of the insurer, an 'intentional failure to determine whether or not there was any lawful basis for refusal,' may use that fact as an element of proof that no lawful basis for refusal ever existed. The relevant question before the trier of fact would be whether a claim was properly investigated and whether the results of the investigation were subjected to a cognitive evaluation and review. Implicit in that test is the conclusion that the

knowledge or reckless disregard of the lack of a legitimate or reasonable basis may be inferred and imputed to an insurance company when there is a reckless indifference to facts or to proof submitted by the insured. Of course, if a lawful basis for denial actually exists, the insurer, as a matter of law, cannot be held liable in an action based upon the tort of bad faith. Otherwise, the insurer's knowledge of the non-existence of any debatable reasons for refusal would be a question for the finder of fact, *i.e.*, the jury."

In *National Security Fire and Casualty Co. v. Bowen*, 417 So. 2d 179 (Ala. 1982), the elements of an action for bad faith which a plaintiff must prove were stated as:

"(a) an insurance contract between the parties and a breach thereof by the defendant;

"(b) an intentional refusal to pay the insured's claim;

"(c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);

"(d) the insurer's actual knowledge of the absence of any legitimate or arguable reason;

"(e) if the intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim."

In *National Savings Life Insurance Co. v. Dutton*, 419 So. 2d 1357 (Ala. 1982), we said that normally in order for a plaintiff to make out a prima facie case of bad faith,

"the proof offered must show that the plaintiff is entitled to a directed verdict on the contract claim

> and, thus, entitled to recover on the contract claim as a matter of law. Ordinarily, if the evidence produced by either side creates a fact issue with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail and should not be submitted to the jury."

In *Dutton* and *National Security Fire and Casualty Co. v. Vintson*, 454 So. 2d 942 (Ala. 1984), we said that once the insurer establishes a debatable basis for denying a claim it has no affirmative duty to investigate further.

In light of these refinements in the law, I believe it is useful to re-evaluate the dimensions of the tort. Justice Embry in his dissent in *Vincent v. Blue Cross-Blue Shield of Alabama*, 373 So. 2d 1054 (Ala. 1979), set forth the policy considerations mandating recognition of the tort of bad faith:

> "Public policy favors the free exercise of rights arising from a contract by the parties to it.
>
> "However, this is not to say that an insurer may in bad faith breach his contract with impunity. The law will not allow an insurer to wilfully refuse to evaluate or honor a claim with the knowledge that the avowed purpose of the insurance contract was to protect the insured at his weakest and most perilous time of need."

As this statement points out, the law should not sanction the intentional conduct of an insurer in either refusing to pay a claim knowing no debatable reason exists for not doing so or simply sitting back and taking no action on the claim. In effect the duty of good faith and fair dealing requires that if an insurer does not pay the claim there must be a debatable reason for not doing so.

When this Court actually "breathed life" into the tort in *Chavers I*, we attempted to define bad faith to encom-

pass either of the evils described above. The first tier of the *Chavers I* standard recognized that an insurer acted in bad faith when it intentionally refused to pay a direct claim knowing that no lawful basis existed for that refusal. Although implicit in *Chavers I, Bowen* held that the plaintiff must prove the lack of a debatable reason. *Bowen* at 183. The second tier of the *Chavers I* standard, the intentional failure to determine the existence of a lawful basis for denying the claim, addresses the second evil, that is, failure to act on the claim. The second tier of the *Chavers I* standard makes it clear that an insurer acts at its peril if it fails to process the claim.

As stated by Justice Beatty in *Barnes,* the second tier is an elaboration on the first. That is, the second tier is also a method by which the insured can circumstantially prove that no debatable reason existed when the claim was denied because the insurer had not investigated the claim. But as *Barnes* also points out, if a debatable reason for denying the claim actually exists, "the insurer, as a matter of law, can not be held liable in an action based upon the tort of bad faith." *Barnes* at 924.

The focusing of the inquiry in bad faith claims on whether there is a debatable reason for denying the claim and generally away from the conduct of the insurer in investigating and evaluating the claim does not mean the law condons an insurer's conduct in not properly investigating and evaluating the claim. It stems from the recognition that without a threshold determination that the insurer had no debatable reason for denying the claim, the insured was in essence not injured, for the insured had no right to immediate payment of the claim.[1] No matter how badly

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[1] The decisions in *Prudential Ins. Co. v. Coleman,* 428 So. 2d 593 (Ala. 1983), *Dutton,* and *Vintson* illustrate that it is the existence or non-existence of the debatable reason that is critical and that once that is established questions of whether the claim was properly investigated and evaluated are essentially moot.

the insurer acted in investigating and evaluating the claim, if there was a debatable reason for refusing to pay the claim, when payment was refused, the insured was not entitled to prompt payment. If a debatable reason exists, the insurer has the "freedom (and, perhaps, the duty) not to honor, and thus legally dispute, claims of questionable validity." *Chavers I* at 6 (quoting from Justice Jones's special concurrence in *Vincent*). The lack of proper investigation and evaluation is significant in proving another element of the tort, namely *knowledge* by the insurer of the lack of a debatable reason. *Barnes* at 924.

Dutton established that if the plaintiff was able to show the insurer lacked a debatable reason for denying the claim, plaintiff would ordinarily be entitled to a directed verdict on the contract claim, and therefore in the normal case a directed verdict on the contract claim was necessary to make out a prima facie case of bad faith. However, as the majority opinion in the present case points out, the conduct of the insurer is to be judged at the time of the denial, based upon the information the insurer had at that time. *Bowen* at 183; *Dutton* at 1362; *Wilkins* at 10. Thus, the *Dutton* test might be more accurately stated as follows: in the normal case the plaintiff should have been entitled to a directed verdict on the contract claim if the directed verdict determination was made on the basis of what had happened at the time of the denial.

I turn now to an examination of the facts in this case to determine whether at the time each denial was made there was a debatable reason for denying the claim.

On March 3, 1977, the hospital completed the appropriate forms and forwarded them along with a "History and Physical Summary," a "Discharge Summary," the physician's progress notes, and various other data, such as the consultation on the EKG, to the Aetna office in Mobile. Included was a bill for $3,028.25. The summaries stated:

"HISTORY AND PHYSICAL SUMMARY

"This 54 year old lady has been followed in the past for mechanical low back pain and osteoarthritis. She had not been seen in our office in about 3 years. She came in with the interval history that she had been retired for 2 years, that her arthritis had become more active over the last several months and she was having generalized arthritis pains in her back, neck and all extremities particularly in the hips, left knee and around the pelvic area. She complains of being very nervous. She said that she has been noticing some intermittent bleeding from the bowel and has a past history of diagnosis of chronic ulcerative colitis. Because of the general exacerbation of her arthritis and the apparent exacerbation of her ulcerative colitis, she is admitted at this time for evaluation and treatment.

"PAST HISTORY: She had gall bladder surgery in 1970, a fibroid tumor removed in 1946 and an exploratory laparotomy in 1953. She has a history of a couple episodes of pnemonia [sic] but denies history of peptic ulcer, hepatitis, rheumatic fever, diabetes or hypertension. She has a questionable history of glaucoma, does not know the severe state of it. She has had episodes of chest pain in the past, about 4 years ago, none recently. No diagnosis or EKG's were done at the time of the pain.

"FAMILY HISTORY: Positive for hypertension and she has a brother who had 1 episode of what was called inflammatory arthritis as a child. No family history of cancer, diabetes or early heart disease.

"DISCHARGE SUMMARY

"54-year-old white female who was admitted with an abdominal pain, osteoarthritis and mechanical low

back pain. She had not been seen in my office for three years when she came in because of general aching and particularly saying that she had had intermittent bleeding from the bowel and had a past diagnosis of chronic ulcerative colitis. We are unable to substantiate this diagnosis in the hospital. In fact, she had a negative GI workup. Her musculoskeletal complaints while she does have some normal amount of osteroarthritis varying from place to place for her age, it is not really outstanding and her general situation suggests that she considerable [sic] psychogenic overlay to her somatic symptoms, and therefore, they are somewhat exaggerated. She has been placed on Mellaril in depth. She has shown some suggestion of slight improvement in the hospital but continues to somaticize her symptoms rather vigorously. It has been explained to her that this is primarily a nervous problem and we have mentioned that she may need the help of a psychiatrist if she does not continue to improve following discharge.

"DISCHARGE DIAGNOSIS: OSTEOARTHRITIS,
MILD PSYCHOPHYSIOLOGIC REACTION
MANIFESTED BY ABDOMINAL PAIN."

The supervisor of the Mobile office of the insurer, Alice Murphy, sent a request to the hospital for further information on March 24, 1977. This letter in pertinent part reads:

> "It would be greatly appreciated if you would send complete hospital records including, admitting and discharge summary, nurses and physicians notes."

On April 5, 1977, before receiving anything further from the hospital, Brenda Harris, a claims worker for Aetna, forwarded the information she had from the hospital to Jean Becker, a "Senior Claims Examiner," in Aetna's

office in Hartford, Connecticut. To the information forwarded, Harris appended a memorandum stating:

> "In our opinion a 23-day confinement for the diagnosis was not necessary. Hospital records do not indicate anything to the contrary."

In pertinent part, Aetna's response reads:

> "DATE: April 27, 1977
>
> ". . . .
>
> "This file has been reviewed with a member of the Medical Dept. On the basis of the limited information submitted, the confinement does not appear to have been medically necessary. We feel this patient could have been evaluated and treated on an out-patient basis.
>
> "Several of the X-ray and lab procedures performed are not usual and customary for the diagnosis given. These include the CAT Scan, EEK and EKG. Since the City of Mobile policy clearly limits coverage to services and supplies which are reasonably necessary for the diagnosis and treatment of nonoccupational disease or injury, room and board charges as well as the aforementioned miscellaneous charges must be denied. Thank you."

The Lavoies received notification, by a letter from Harris, on June 3, 1977, which reads in full:

> "After having this file reviewed by our Medical Department we must, at his time, deny benefits for room and board charges.
>
> "From the information we submitted to them it appears the evaluation and test could have been performed on an out-patient basis. Also, we must deny charges for the CT Brain Scan, EEG and EKG since

they are not usual and customary procedures for the diagnosis given.

"If you have any questions please feel free to contact this office."

The defendant then paid the hospital for the medical diagnostic tests, other than the EEG, EKG, and CAT scan, physical therapy and a back brace. Dr. Douglas was paid $300.20 and the Lavoies were paid $217.34 directly. The parties stipulated the remainder on the claim was $1,650.22.

Under the insurance policy Aetna was only bound to pay for expenses arising from treatments, procedures, etc., that were medically necessary. The denial of payment of some of the expenses was on the basis that Aetna decided some expenses were not medically necessary. Was it reasonably debatable *at that time* that the denied expenses were medically necessary? Under these facts, I think not.

There is credible evidence from which the jury could conclude that the Lavoies' claim was never reviewed by Aetna's medical department. The fact that it is debatable whether the claim was reviewed by the medical department is not the sort of factual controversy that is sufficient to defeat a bad faith claim. When the facts which create a debatable reason emanate from the insurer, a blind adherence to the directed verdict rule would essentially abolish the tort. See *Safeco Ins. Co. v. Sims,* 435 So. 2d 1219 (Ala 1983) (Jones, J., concurring specially). If, in fact, the claim was not reviewed by the medical department, what facts would allow Aetna to say it was debatable whether the expenses were medically necessary? While I am not prepared to say that under no circumstances would an experienced claims examiner be able to determine that certain medical expenses were medically unnecessary, there is no evidence that the examiners who handled this claim had the experience to do so nor that they made the decision based upon their own experience. In fact, the testi-

mony here indicates that the examiners knew that medically trained personnel needed to review the claim. Therefore, I conclude that at the time Aetna first denied the claim it had no debatable reason for doing so.

However, it is interesting to note that this appears to be a case where the insurer thought there was a debatable reason for denying the claim and could have established one, and did establish one after the first denial. Dr. Swan apparently did review the Lavoie file before the second denial was made. At that point, assuming that there was no evidence that Dr. Swan lied, Aetna established credible medical evidence that the expenses did not result from medically necessary procedures. Expert testimony at trial supports Dr. Swan's initial determination.

While Aetna's conduct in reviewing the claim after the initial denial was questionable, I believe that Aetna was justified in denying the claim based upon the advice of Dr. Swan.[2] Establishing a debatable reason for denying the claim after the initial denial forecloses any determination that the subsequent refusals to pay were made in "bad faith", in the absence of new information eliminating the debatable reason at the time of those refusals.

However, it is not sufficient simply to find that no debatable reason exists for refusing to pay the claim. The plaintiff must also show that the insurer *knew* that no debatable reason existed. *Bowen, supra.* Here the testimony shows that Brenda Harris questioned the propriety of a 23-day hospital stay and thought it was medically unnecessary. Apparently Jean Becker, the senior claims examiner who actually denied the claim, believed that the expenses were not medically necessary. While the knowledge element

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[1] While there is controversy concerning exactly what materials were in the Lavoie file when reviewed by Dr. Swan, the expert evidence offered at trial was to the effect that even if everything available to Aetna was in the file there was still a debatable question as to whether all procedures were medically necessary.

of the tort, like any mental state requirement in any tort, almost always must be proved circumstantially, I am unable to find any evidence that would authorize a jury to find that Aetna knew no debatable reason existed. In fact, the evidence supports the conclusion that Aetna thought, and, as it turns out, was correct in thinking, that a debatable reason did exist and therefore that denial of the claim was proper.

I conclude that while the Lavoies proved that initially there was no debatable reason for denying the claim, they did not prove that Aetna knew there was no debatable reason for denying the claim, and therefore the judgment for them on the bad faith claim should be reversed.

Beatty, JJ., concurs.

MADDOX, JUSTICE (Dissenting).

Admittedly, the facts of this case are such that it would appear from the facts set out in the majority opinion that the insurer was guilty of a bad faith refusal to pay an insurance claim, but when the basic facts necessary to a resolution of this case are examined against the rule of law established in bad faith cases, it is apparent that the insureds were not entitled to recover on the bad faith claim, because they failed to meet their burden of showing that the insurer "had no legal or factual defense to the insurance claim." *National Security Fire & Casualty Company v. Vintson,* 454 So. 2d 942 (Ala. 1984).

In *Vintson,* in which the Chief Justice and every Associate Justice concurred, except Justice Faulkner, who concurred in the result, this Court reviewed the law of bad faith refusal to pay an insurance claim, and concluded that when a claimed misrepresentation by a company agent presents a jury question, a "debatable reason" exists for denying liability on a bad faith claim. Because *Vintson* is the latest expression of the law of bad faith refusal to pay an insurance claim, and because every member of

this Court concurred in the opinion or the result reached in the opinion, I believe it would be instructive to quote extensively from that opinion, because the facts in this case are not so dissimilar that a different result should be reached here from what was reached in that case. There, the Court opined:

> "Before we consider whether the denial of the directed verdict was proper under the specific facts of the present case, we look first at the evolution of the tort of bad faith refusal to pay a direct insurance claim in this state. This Court stated in *Chavers v. National Security Fire & Casualty Co.*, 405 So. 2d 1, 7 (Ala. 1981):
>
> > "'[A]n actionable tort arises for an insurer's intentional refusal to settle a direct claim where there is either "(1) no lawful basis for the refusal coupled with actual knowledge of that fact or (2) *intentional failure to determine whether or not there was any lawful basis for such refusal.*"' (Emphasis added.)
>
> "Later, in *National Security Fire & Casualty Co. v. Bowen*, 417 So. 2d 179, 183 (Ala. 1982), we held:
>
> > "'No lawful basis "means that the insurer lacks a legitimate or arguable reason for failing to pay the claim." *Gulf Atlantic Life Ins. Co. v. Barnes*, Ala., 405 So. 2d 916 (1981). When a claim is "fairly debatable," the insurer is entitled to debate it, whether the debate concerns a matter of fact or law. *Ibid.*
>
> > "'Under those authorities the plaintiff in a "bad faith refusal" case has the burden of proving:
>
> > "'(a) an insurance contract between the parties and a breach thereof by the defendant;

"'(b) an intentional refusal to pay the insured's claim;

"'(c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);

"'(d) the insurer's actual knowledge of the absence of any legitimate or arguable reason;

"'(e) if the intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim.

"'In short, plaintiff must go beyond a mere showing of nonpayment and prove a *bad faith* nonpayment, a nonpayment without any reasonable ground for dispute. Or, stated differently, the plaintiff must show that the insurance company had no legal or factual defense to the insurance claim. [Emphasis in original.]

"'The "debatable reason" under (c) above means an arguable reason, one that is open to dispute or question. Webster's Third New International Dictionary (1931) at 116. See *Chavers* at 10; see also Embry, J., concurring on rehearing in *Aspinwall v. Gowens*, Ala., 405 So. 2d 134 (1981).'

"More recently in *National Savings Life Ins. Co. v. Dutton*, 419 So. 2d 1357 (Ala. 1982), this Court emphasized the heavy burden that a plaintiff must bear in a bad faith case. *Dutton, supra*, held:

"'In the normal case in order for a plaintiff to make out a prima facie case of bad faith refusal to pay an insurance claim, the proof offered must show that the plaintiff is entitled to a directed

> verdict on the contract claim and, thus, entitled to recover on the contract claim as a matter of law. Ordinarily, if the evidene produced by either side creates a fact issue with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail and should not be submitted to the jury.' 419 So. 2d at 1362.
>
> "*Dutton* also stated that '[w]hether an insurance company is justified in denying a claim under a policy must be judged by what was before it at the time the decision is made.' "

Vintson, supra, at 944.

In *Vintson,* the insured had claimed that an agent of the insurer had told him he had fire insurance coverage, and the insurer had later denied that there was coverage. Because of this dispute between the insurer and the insured, this Court, in *Vintson,* held that "[t]here was conflicting testimony concerning [a] conversation between Vintson [the insured] regarding the time that the policy would take effect," and held that the insured failed to establish a bad faith failure to pay an insurance claim.

In this case, the crucial factual question was whether the 23-day hospital confinement and the diagnostic tests were reasonably necessary in view of the discharge diagnosis, which without question read:

"OSTEOARTHRITIS, MILD
PSYCHOPHYSIOLOGIC
REACTION MANIFESTED
BY ABDOMINAL PAIN."

The insurer concedes that the insureds made out a *prima facie* case on their contract claim, but they do not concede that the insureds met their burden of showing that they were entitled to recover on the contract claim as a

matter of law; consequently, they contend that the insureds failed to show they were entitled to a directed verdict on their contract claim. The insureds agree with the insurer in this contention.

They candidly admit that the evidence was conflicting on whether the 23-day hospital stay, the EKG, EEG, and CAT scan were, without question, medically necessary, but they contend that what they describe as the "physician war" which occurred at the trial of the case was merely a "side show" and was put on by the insurer "to obscure, for both the jury and the judge and for this Court on appeal, those acts of fraud, conspiracy and intentional deceit perpetrated upon its insured during the course of its handling of the claim." They claim that they proved that the insurer intentionally violated its own in-house procedures for the handling of claims, intentionally refused to review the most important medical information which could be submitted in a given case (the treating physician's narrative report), intentionally lied to its insureds, intentionally engaged in cover-up activities in an attempt to "whitewash" its conduct, intentionally committed perjury during the course of discovery connected with the case on the most critical issues involved in the case, and intentionally refused to obtain the nurses' notes during the course of its four reviews of the claim. The majority believes that proof of these facts, if believed by the jury, would authorize the recovery against the insurer of $3.5 million in punitive damages. I do not agree, because I cannot classify the conduct by the insurer's agents in this case to be any more reprehensible than the conduct of the insurer's agent in *Vintson*.

Admittedly, there was evidence that at the time the insurer initially denied the claim and stated that the claim had been reviewed by a member of the "medical department," that, in fact, it had not been reviewed by a member of the insurer's medical department; admittedly, there was

evidence that the Mobile claims representative had stated in a letter to an attorney for the insureds that she had checked with the insurer's "Medical Department," when, in fact, she had only checked with the senior claims representative; admittedly, there was evidence that the senior claims representative, Hutton, had given testimony in a deposition which was in conflict with testimony given by him during the trial of the case; admittedly, there was conflicting evidence regarding the date when the claim was reviewed by the medical department. The insureds contended that the evidence supported a finding that the review by the medical department was on April 28, 1977, the day after the denial of the claim, instead of April 25, 1977, as testified to by a witness for the insurer; and, admittedly, there was conflicting evidence whether the treating physician's narrative report was ever in the insurer's home office file.

Even assuming, however, that each of the insureds' contentions was proven to the reasonable satisfaction of the jury, the crucial issue in this *bad faith* case, as it is in every bad faith case, is whether the insureds showed that the insurer "*had no legal or factual defense to the insurance claim.*" (Emhasis added.) *Vintson, supra.* I believe that the insureds failed to meet the burden of proof as required by *Vintson.* Two of the five doctors testifying at the trial stated that the insurer's actions in denying the claim were reasonable because the charges in question were not shown to be medically "necessary for the treatment of the injury or disease concerned," which was the language of the policy exclusion.

Based on the evidence presented, and applying the law of bad faith as I understand it to be spelled out in *Vintson,* I can only conclude that the insureds failed to meet their burden of showing that the insurer "had no legal or factual defense to the insurance claim." *Vintson, supra.*

I realize that the evolution of the tort of bad faith has been difficult, and that the Court has expressed differing views on the standards to be used by the bench and bar in determining when and under what circumstances the tort was established, but in *Vintson,* this Court clearly established these principles in a succinct and understandable opinion. The principles of law laid down in that decision should be applied in this case; consequently, I must respectfully dissent.

There is an additional reason why the claim for bad faith refusal to pay should not be allowed in this action. The insurer promptly paid a portion of the claim, but denied that portion of the claim which it deemed not covered by the terms of the policy. This partial payment made under the policy, in my opinion, is an additional fact which precludes a finding of bad faith refusal to pay in this case. *Sexton v. Liberty National Life Ins. Co.,* 405 So. 2d 18 (Ala. 1981); *National Security Fire & Casualty Co. v. Bowen,* 417 So. 2d 179 (Ala. 1982).

In each of those cases, this Court concluded that, because the insurer had paid a portion of the claim, there was no refusal to pay, and that the insured in each case had failed, therefore, to prove a prima facie case of bad faith refusal to pay. Similarly, in *Cincinnati Ins. Co. v. Little,* 443 So. 2d 891 (Ala. 1983), this Court addressed the legal effect of a partial payment when the issue of a bad faith refusal to pay a claim is at issue.

I do not suggest that partial payment by an insurer of a claim would preclude a finding of bad faith refusal to pay in every case; otherwise, an insurer could escape liability for tort, even though the evidence might show that the insured was a victim of an intentional denial of a claim which was not otherwise reasonably debatable;[1]

---

[1] Cf. *Berry v. United of Omaha,* 719 F. 2d 1127 (11th Cir. 1983) (applying Alabama law; full payment of claim prior to suit

however, in this case, the payment of a "substantial" portion of the claim under the policy is consistent with insurer's claim of good faith denial of the remainder.

Assuming, arguendo, that the insureds did prove their claim for bad faith refusal to pay, I am of the opinion that there is no justification to support an award of punitive damages in the sum of $3,500,000. In *Gulf Atlantic Life Ins. Co. v. Barnes,* 405 So. 2d 916 (Ala. 1981), this Court found that a judgment rendered against an insurance company in the amount of $1,100,000 was "excessive and obviously the result of passion and prejudice on the part of the jury." In *Barnes,* this Court directed the trial court to require a remittitur in the amount of $1,000,000 as a condition to the denial of a new trial.

In *Johnson Publishing Co. v. Davis,* 271 Ala. 474, 124 So. 2d 441 (1960), this Court found a jury verdict awarding plaintiff $67,000 was excessive; there, this Court directed a remittitur of all but $45,000 of the judgment as a condition for affirming the judgment.

Based on the above, I am of the opinion that the verdict of the jury awarding the insureds $3,500,000 is excessive and if the judgment below is to be affirmed, this Court should direct a remittitur.

Shores, J., concurs.

---

is not a defense if the initial refusal to pay was made in bad faith). *See also* Blan, *The Tort of Bad Faith—A Defense Viewpoint,* 34 Ala. L. Rev. 543 (1983), Heninger, *Bad Faith in Alabama: An Infant Tort in Intensive Care,* 34 Ala. L. Rev. 463 (1983).

APPENDIX B

82-426 & 82-1152

AETNA LIFE & CASUALTY CO., INC.

v.

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.

ON MOTION FOR DISQUALIFICATION AND APPLICATION FOR REHEARING

[Filed Mar. 8, 1985. Clerk, Supreme Court of Alabama]

PER CURIAM.

Pending appellant's application for rehearing, the appellant has filed a motion in this cause styled "Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984, and for Hearing De Novo."

Upon consideration, the Court is of the opinion that under the allegation of said motion in this case each justice should vote individually on the matter of whether or not he or she is disqualified and should recuse. Each justice having voted not to recuse,

IT IS, THEREFORE, ORDERED that the "Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984, and for Hearing De Novo" be, and the same is hereby, denied.

Faulkner, Almon, Embry, Beatty, and Adams, JJ., concur.

Tolbert, C. J., and Maddox, Jones, and Shores, JJ., concur specially, with opinions by Torbert, C.J., and Maddox, J.

APPLICATION FOR REHEARING OVERRULED.

Faulkner, Jones, Almon, Embry, and Adams, JJ., concur.

Torbert, C. J., and Maddox, Shores, and Beatty, JJ., dissent.

TORBERT, CHIEF JUSTICE (concurring specially as to the ruling on the motion for disqualification).

I am in accord with the views expressed herein by Justice Maddox with respect to the issue of whether the Court as a body, or the individual justices, should make the determination as to the disqualification of one or more of its members. I agree on the basis of the American Bar Association standards cited; but more importantly, the alleged disqualification here is more subjective than objective, as would be the case where a judge is related to a party or counsel or where a judge has a direct financial interest in the outcome of litigation. The question of disqualification under the factual assertions of appellant's motion addresses itself to the ethical judicial conscience of each justice applied in accordance with the established rules of law set forth in the opinion by Justice Maddox.

Appellant contends that I am disqualified because I "may have an interest as a possible class member plaintiff in the circuit court action filed by Justice T. Eric Embry and as such [have] an interest that could be substantially affected by the outcome of this case."

I have stated my opinion in the dissent filed in this case on its original deliverance. Moreover, my views have also been expressed in other similar cases heard before this Court. I find them altogether consistent. In addition, I have carefully reviewed my file in this matter throughout the time of its consideration before the Court, both upon its original submission on briefs and after that submission was withdrawn and the case was again submitted after oral argument. The filing of actions by a fellow justice against

other insurers in no way influenced or affected my consideration of this appeal.

As to the class action aspect of the allegations of appellant's motion, I too, will not allow myself to be included in the alleged class. The circuit court where the action is pending will be so advised.

It is obvious that the Court had great difficulty in the resolution of this appeal. The case was hotly contested in the trial court by able counsel, strongly argued here, and affirmed by a divided Court. It is indeed unfortunate that the litigation has resulted in a serious charge impugning the honesty and integrity of the Court and its members.

MADDOX, JUSTICE (Concurring specially as to the ruling on the motion for disqualification).

Aetna's Motion for "Disqualification and Motion for Withdrawal of Opinion of December 7, 1984. and for Hearing De Novo," in pertinent part reads as follows:

> "COMES now the Appellant, AETNA LIFE INSURANCE COMPANY, and moves Justice T. Eric Embry to disqualify himself from considering the Appellant's pending application for rehearing, that the remaining Justices of this Court disqualify themselves as Justices considering the appellant's pending application for rehearing, for this Honorable Court to withdraw its opinion of December 7, 1984, which affirmed the verdict of the trial court, for the Clerk of the Supreme Court to certify the disqualifications of the Justices to the Governor of the State of Alabama in accordance with § 12-2-14, *Code of Alabama, 1975,* and for the special court to hear this case *de novo.* As grounds for said motion, appellant states as follows:
>
> > "1. That on January 19, 1984, after this case was submitted to this Honorable Court for consideration, Justice T. Eric Embry filed an action

in the District Court of Jefferson County, Alabama, which is styled as follows, *T. Eric Embry v. Maryland Casualty Company,* Civil Action No. DV-84-00963, which was dismissed on April 6, 1984. . . .

"2. That on January 30, 1984, after this case was submitted to this Honorable Court for consideration, Justice T. Eric Embry filed an action in the Circuit Court of Jefferson County, Alabama, which is styled as follows, *T. Eric Embry, etc.* v. *Blue Cross/Blue Shield of Alabama,* Civil Action No. CV-84-500-447, and which is still pending in the Jefferson County Circuit Court. . . .

"3. In the Circuit Court of Jefferson County lawsuit against Blue Cross/Blue Shield, Justice T. Eric Embry alleges on behalf of himself and on behalf of a class of all state employees, among other things, that the failure of the defendant insurance company to pay a portion of his medical and hospital claim and delays in the payment of his claim by the defendant insurance company were committed in bad faith. In the District Court of Jefferson County lawsuit, Justice T. Eric Embry, individually, alleged that the defendant insurer in bad faith refused to pay his claim. Both cases demanded the imposition of punitive damages against the respective defendant insurers.

"4. On February 14, 1985 and/or February 15, 1985, the appellant, through its attorneys, was made aware that Justice T. Eric Embry was a party plaintiff in the suits alleging bad faith. . . .

"5. Under the *Alabama Canons of Judicial Ethics,* Canon 3.C(1)(d)(ii), a Judge should disqualify himself in a proceeding in which his impartiality might reasonably be questioned if the

Judge has an interest that could be substantially affected by the outcome of the proceeding. Further, the law of Alabama, as set forth in the attached brief, clearly mandates that Justice T. Eric Embry was disqualified from considering and participating in this case and that each Justice of this Court is also disqualified.

"6. Each Justice of this Court participated in the Opinion of December 7, 1984, and *may have an interest as a possible class member plaintiff in the Circuit Court action filed by Justice T. Eric Embry and as such has an interest that could be substantially affected by the outcome of this case.*

"• • • • •

"10. Due to the disqualification of Justice T. Eric Embry and all the Justices of this Court, the Court must withdraw its opinion of December 7, 1984, for the Clerk of the Supreme Court to certify these disqualifications to the Governor of the State of Alabama, and for the special court to reconsider *de novo* this case in its entirety, as required by the Due Process Clause of the Fourteenth Amendment to the Federal Constitution.

"11. The undersigned attorneys are duly and legally admitted to practice law by the Supreme Court of Alabama, are now attorneys in good standing of the Bar of this Court and hereby certify that this motion is filed in good faith and is filed because the undersigned have an obligation to the court as well as to our client. We owe the public a duty to aid the administration of justice, to uphold the dignity of the court and to respect its authority. . . ." (Emphasis added.)

As is apparent from the motion itself, the primary thrust of the motion, particularly paragraph 5, is that Mr. Justice T. Eric Embry is disqualified because of the provisions of

Alabama Canons of Judicial Ethics, Canon 3.C(1)(d)(ii). Every other Justice is alleged to be disqualified because "[e]ach Justice of this Court participated in the opinion of December 7, 1984, and may have an interest as a possible class member plaintiff in the Circuit Court action filed by Justice T. Eric Embry and as such has an interest that could be substantially affected by the outcome of this case." Canon 3.C(1)(d)(ii) provides:

> "C. Disqualification:
>
> "(1) A judge should disqualify himself in a proceeding in which his disqualification is required by law or his impartiality might reasonably be questioned, including but not limited to instances where:
>
> "• • • • •
>
> "(d) He or his spouse, or a person within the fourth degree of relationship to either of them, or the spouse of such a person:
>
> "• • • • •
>
> "(ii) Is known by the judge to have an interest that could be substantially affected by the outcome of the proceeding."

As I understand the motion, it is directed to me only insofar as I "may have an interest as a possible class member plaintiff in the Circuit Court action filed by Justice T. Eric Embry."

Insofar as I am personally concerned, the movant has failed to show that I am disqualified, but to prevent any question on the matter, I am going to request the clerk of this Court to certify a copy of this special concurrence to the Tenth Judicial Circuit, and to notify the Circuit Court that I do not desire to be a member of any class which has been, or may be, certified in *T. Eric Embry, etc. v. Blue Cross/Blue Shield of Alabama*, Civil Action No. CV-84-500-447.

Recusal is required only where "facts are shown which make it reasonable for members of the public, or a party, or counsel opposed to question the impartiality of the judge." *Acromag-Viking v. Blalock*, 420 So. 2d 60, 61 (Ala. 1982).

Recusal is not required by a mere allegation of bias unsupported by substantial fact. *Acromag-Viking* v. *Blalock, supra.* Because I have no personal interest in the action filed by Mr. Justice Embry, I am not disqualified. I have no personal bias against the movant or any other party to the litigation, although my views *on the law* relative to "bad faith" actions is set out not only in my dissent in this case, but in others also.

By writing this special concurrence, I should not be understood as expressing an opinion on the question of whether any other member of this Court should or should not be disqualified, because I believe that the question of recusal of an appellate judge can be decided better by the judge himself.[1] My view comports with the American Bar Association Standards Relating to Appellate Courts, Section 3.42, which provides:

> "3.42 Disqualification of Judges. A judge of an appellate court should be subject to disqualification on the grounds set forth in the Code of Judicial Conduct recommended by the American Bar Association, and in any case in which the judgment under review is one by a court in whose decision he participated as a judge in a lower court.
>
> "*Commentary*
>
> "An appellate judge should be subject to challenge

---

[1] In *Duncan v. Johnson*, 338 So. 2d 1243 (Ala. 1976), I recused myself because a justice had represented one of the parties to the litigation. See also, *Simpson v. City of Montgomery*, 282 Ala. 368, 211 So. 2d 498 (1968).

for cause on the same grounds as a trial judge, and also when an appeal involves a review of his own decision. The most difficult problem concerns the procedure to be employed. As in the challenge of a trial judge, if the challenge is sufficient on its face and any reasonable doubt of the judge's disinterestedness is suggested, the judge may be expected to disqualify himself. If he does not do so, in the case of a trial judge factual issues relating to disqualification should properly be determined by another judge. See § 2.32, Standards Relating to Trial Courts. In the case of an appellate judge, however, that procedure would subject the judge to decision of his disinterestedness by official peers with whom he may continue to serve in a collegial capacity in deciding the case. Moreover, because an appellate court decides questions of law rather than fact, the question of an appellate judge's 'bias' is often practically indistinguishable from the question of his views on the law, which are not properly subject to disputation through the recusal procedure. Given these complications, it is better that the question of recusal be decided by the judge himself. If he is a judge of an intermediate appellate court, there remains the remedy of appeal from a decision in which he participates; if he is a judge of a supreme court, reliance must be placed on his recognition that a court should not only be disinterested but that it should appear to be so.

"In some jurisdictions, peremptory challenge of a trial judge is permitted. See Commentary to § 2.32(b), Standards Relating to Trial Courts. This procedure is inappropriate in the case of an appellate judge. In the collegial decision-making of an appellate court an individual judge's purely personal views are of less significance than they would be in a trial court and he is subject to collegial restraint should he be inclined to act on them; an appellate judge has few occasions

for exercising the broad discretion reposing in a trial judge; and in appellate litigation there is no occasion for the intense personal interaction between the judge and the lawyers and litigants that may occur in a trial court. Moreover, an appellate judge's established views on law and justice, at least up to a point, are a proper element of the contribution he makes to the function of an appellate court, particularly in the development of the law. A peremptory challenge might easily be abused to exclude a judge solely because a litigant disagreed with his views."

See, also *State ex rel. Wild v. Otis*, 257 N.W. 2d 361 (Minn. 1977); contra: *State ex rel. Short, Atty. Gen., v. Martin*, 256 P. 681 (Okla. 1927) (Supreme Court has power to disqualify any one or more of its members from participating in a case).

In determining that I am not disqualified, I have applied the following test, set out in *Ex parte Cornwell*, 144 Ala. 497, 498-99, 39 So. 354 (1905):

"It is true that the respondent has no direct, pecuniary interest in the result of the prosecution by the State against the petitioner on the pending indictments. And, if the question of disqualification were left to be determined alone by the terms of the statute, § 2637 of the Code, under the facts in the present case, no disqualification could be said to exist. But, under the common law, there are other grounds than those mentioned in the statute, which go to the disqualification of the judge.

"In *Gill v. State*, 61 Ala. 172, it was said, 'According to the stern morality of the common law, a judge is required to be legally indifferent between the parties.' In *Freeman on Judgments*, § 145, it is said to be 'Well settled by the common law that no judge ought to act where, from interest or any other cause, he is supposed

to be partial to one of the suitors.' Any interest, the probable and natural tendency of which is to create a bias in the mind of the judge for or against a party to the suit, is sufficient to disqualify. The judge is human, and human nature at best is weak, and as far as it is possible a perfect equipoise should always be preserved in the administration of justice by the courts. Pecuniary interest in the result of the suit is not the only disqualifying interest. If such were true, there would exist no disqualification in the judge to try a defendant on a charge of arson in the burning of the house of the judge. And yet no one would for a moment question the existence of such an interest in the result of the trial, the probable and natural tendency of which would be to create a bias, that would affect the competency of the judge."

Based on the foregoing, I am of the opinion that it is better that the question of recusal of an appellate judge be decided by the judge himself, and I have determined that the movant has failed to show that I should disqualify myself in this case; therefore, I am of the opinion that the movant's request is due to be denied.

APPENDIX C

THE STATE OF ALABAMA — — — — JUDICIAL DEPARTMENT

IN THE SUPREME COURT OF ALABAMA

March 25, 1985

82-426

Mobile Circuit Court

CV-78-001614

AETNA LIFE & CASUALTY INSURANCE COMPANY

v.

MARGARET W. LAVOIE AND ROGER J. LAVOIE, SR.

ORDER

Appellant Aetna Life Insurance Company having filed a motion in this Court, with amendment thereto, wherein it requests this Court to suspend the requirements of Rule 40, Alabama Rules of Appellate Procedure, and to grant it leave to file a second application for rehearing and further for a stay of judgment pending determination of the motion to suspend the rules or to advance the motion to suspend the rules on its docket so that it will be ruled upon prior to March 26, 1985; and, in the event the Court denies the motion to suspend the rules, appellant asks that its motion for stay of execution of judgment be treated as a motion for stay pending the timely filing of a jurisdictional statement in the Supreme Court of the United States; and the same having been submitted and duly considered by the Court, it is considered that the relief requested by the appellant is due to be denied.

IT IS, THEREFORE, ORDERED that the motion to suspend rules and motion for stay of execution of judgment

and the amendment to motion to suspend rules and motion for stay of execution of judgment be, and the same are hereby, denied.

Torbert, C. J., and Maddox, Faulkner, Almon, Shores, Embry, Beatty, and Adams, JJ., concur.
Jones, J., not sitting.

I, Robert G. Esdale, as Clerk of the Supreme Court of Alabama, do hereby certify that the foregoing is a full, true and correct copy of the instrument(s) herewith set out as same appear(s) of record in said Court.

Witness my hand this 25th day of Mar. 1985.

/s/ Robert G. Esdale
Clerk, Supreme Court of Alabama

APPENDIX D

April 2, 1985

THE STATE OF ALABAMA — — — — JUDICIAL DEPARTMENT

IN THE SUPREME COURT OF ALABAMA

82-426 and 82-1152

AETNA LIFE & CASUALTY INSURANCE COMPANY, INC.

v.

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.

MOBILE CIRCUIT COURT #CV-78-001614

This cause having been duly submitted, IT IS CONSIDERED, ORDERED AND ADJUDGED that the judgment of the circuit court be affirmed.

IT IS FURTHER ORDERED AND ADJUDGED that the appellant, Aetna Life & Casualty Insurance Company, Inc., and Aetna Casualty & Surety Company, surety on the supersedeas bond, pay the amount of the judgment of the circuit court plus ten percent damages and interest and the costs of appeal as provided by the Alabama Rules of Appellate Procedure, for which let execution issue.

OPINION PER CURIAM

FAULKNER, JONES, ALMON, EMBRY AND ADAMS, JJ., CONCUR; TORBERT, CJ., MADDOX, SHORES AND BEATTY, JJ., DISSENT.

APPENDIX E

IN THE SUPREME COURT OF ALABAMA

AETNA LIFE INSURANCE CO., *Appellant*

-VS-

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR., *Appellees*

On Appeal From The Circuit Court of Mobile County, Alabama

BRIEF OF
DEFENDANT, AETNA LIFE INSURANCE COMPANY
PETITION FOR REHEARING

[Filed Dec. 28, 1984. Clerk, Supreme Court of Alabama]

SINTZ, PIKE, CAMPBELL & DUKE
Peter V. Sintz
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Attorney for Aetna Life Insurance Company

ORAL ARGUMENT REQUESTED

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ISSUE X

The Errors Committed Have Resulted In A Violation Of Aetna's Rights Under The Constitution Of The United States

If this decision is allowed to stand, one consequence of the errors committed is that Aetna's rights under the Constitution of the United States will be infringed. Not only will Aetna be deprived of its property without due process, but Aetna will be subjected to a confiscatory and excessive fine. In addition, Aetna will have been denied equal protection of the law.

A. *The Decision Of This Court, By In Essence Retroactively Reversing Numerous Well Settled Precedents And As A Result Of Those Reversals, Imposing A $3.5 Million Penalty Constitutes An Excessive Fine And An Unlawful Taking of Property In Violation Of Aetna's Right To Due Process.*

As is established elsewhere in this brief, the law in Alabama was clear in three areas prior to the decision in

this case. First, to make out a prima facie case of bad faith refusal to pay an insurance claim, the proof offered had to show that the plaintiff was entitled to a directed verdict on the underlying contract claim. *National Savings Life Insurance Co. vs. Dutton,* 419 So.2d 1257 (Ala. 1982); *National Security Fire & Casualty Co. vs. Bowen,* 417 So. 2d 179 (Ala. 1982). Second, partial payment of a claim, based upon some reasonable rationale, indicated a lack of bad faith. *Sexton vs. Liberty National Life Insurance Co. vs. Bowen,* 417 So.2d 179, 186 (Ala. 1982). Third, it was uniformly held to be improper to allow evidence of the plaintiff's financial condition to be introduced at trial. *Southern Life & Co. vs. Whitman,* 358 So.2d 1025 (Ala. 1978). In each instance, these long standing rules of law were reversed by the decision of this Court in *Aetna Life Insurance Co. Inc. vs. Lavoie.* Aetna submits that to impose ex post facto, a $3.5 million penalty based upon newly enunciated legal principles which effectively reverse substantial bodies of prior law, constitutes an unlawful taking of property without due process, and is prohibited under the Fifth and Fourteenth Amendments to the Constitution of the United States. In addition, Aetna urges that such a result is the imposition of an excessive fine proscribed by the Eighth Amendment to the Constitution of the United States.

Finally, the manner in which the punitive damage award was determined constitutes a denial of due process of law and the amount of the punitive damage award, in proportion to the alleged actual damage is arbitrary, capricious, irrational and confiscatory in violation of the Fifth and Fourteenth Amendments to the Constitution of the United States.

B. *The Imposition Of A Ten Percent Penalty If A Money Judgment Is Affirmed On Appeal Constitutes A Violation Of Both Due Process And Aetna's Right To Equal Protection Under The Law.*

Code of Alabama § 12-22-72 (1975) provides that if an Appellate Court affirms a money judgment, it must then impose what is in effect a ten percent penalty on the unsuccessful appellant. Of course, this statute operates only against defendants since they are the only litigants with money judgments running against them. Such a penalty undoubtedly has an in terrorem effect on a defendant's ability to exercise his right of appeal. In addition, it certainly imposes an unfair burden on defendants, in terms of equal access to the courts.

Aetna submits that to impose such a penalty violates its right to due process and its right to equal protection, both protected by the Fourteenth Amendment of the Constitution of the United States.

The result in *Aetna Life Insurance Co., Inc. vs. Lavoie* cannot stand when measured against the rights protected by the Constitution. The imposition of a $3.5 million fine based upon retroactive revocation of long standing legal rules, and the imposition of an additional ten percent penalty based solely on this appellant's lack of success on appeal are contrary to any notion of fairness. Aetna submits the decision must be reversed.

STATEMENT IN SUPPORT OF REQUEST FOR ORAL ARGUMENT

Defendant has requested that oral argument be granted on rehearing. The majority opinion has drastically changed the law in three respects. First, with respect to wealth or poverty of a party when mitigation of damages is not and never was an issue in the case. Second, with respect to the rights of an insurance carrier to question part of a claim

when there exists a question of fact. Third, the majority has ignored the effect of the defendant's substantial partial payment.

The majority opinion admitted that the evidence at trial showed the existence of a question of fact on the contract claim, but held it made no difference in this case. This decision has far reaching impact on the insurance industry and both the plaintiffs' and defense bar in prosecuting and defending bad faith cases and in attempting to advise clients.

In addition, there are numerous factual errors relied upon by the majority. For example, the opinion quoted testimony of Brenda Harris which was never read to, heard by or considered by the jury. The documentary evidence affirmatively showed that the Defendant's Assistant Medical Director Bernard Swann ACTUALLY received and reviewed the treating physician's report of 11/4/77 which the the majority said is not so. The majority omitted and overlooked the investigative efforts that were ongoing by Aetna, such as seeking peer review by the Mobile Infirmary, meeting with the City of Mobile Insurance Committee, attempting to get additional medical records from the Mobile Infirmary and reports of the treating physician, Dr. John Douglas.

Lastly, the errors in the majority opinion have resulted in a violation of the defendant's rights guaranteed under the Constitution of the United States of America.

Wherefore, the Defendant prays that this Court grant oral argument on its Application for Re-Hearing in this cause.

/s/ Peter V. Sintz
Peter V. Sintz

/s/ William M. Cunningham, Jr.
William M. Cunningham, Jr.

Of Counsel:
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CERTIFICATE OF SERVICE

I hereby certify that I have on this 28th day of December, 1984, served a copy of the foregoing Brief In Support of Application for Rehearing by mailing a copy of same by United States mail, postage prepaid and properly addressed as follows:

Hon. Joseph M. Brown, Jr.
Post Office Box 66705
Mobile, AL 36660

Hon. Edgar M. Elliott, III
Hon. Karon O. Bowdre
1700 Financial Center
Birmingham, AL 35203

Hon. Harry Cole
P. O. Box 116
Montgomery, AL 36195

Hon. James T. Upchurch
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Montgomery, AL 36195

Hon. Charles Graddick
Attorney General
Montgomery, AL

/s/ PETER V. SINTZ
Peter V. Stinz

APPENDIX F

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

MOTION FOR DISQUALIFICATION AND MOTION FOR WITHDRAWAL OF OPINION OF DECEMBER 7, 1984 AND FOR HEARING DE NOVO

COMES now the Appellant, AETNA LIFE INSURANCE COMPANY, and moves Justice T. Eric Embry to disqualify himself from considering the Appellant's pending application for rehearing, that the remaining Justices of this Court disqualify themselves as Justices considering the appellant's pending application for rehearing, for this Honorable Court to withdraw its opinion of December 7, 1984, which affirmed the verdict of the trial court, for the Clerk of the Supreme Court to certify the disqualifications of the Justices to the Governor of the State of Alabama in accordance with § 12-2-14, *Code of Alabama, 1975,* and for the special court to hear this case *de novo.* As grounds for said motion, appellant states as follows:

1. That on January 19, 1984, after this case was submitted to this Honorable Court for consideration, Justice T. Eric Embry filed an action in the District Court of Jefferson County, Alabama, which is styled as follows, *T. Eric Embry v. Maryland Casualty Company,* Civil Action No. DV-84-00963, which was dismissed on April 6, 1984. (See a copy of said suit which is attached hereto and marked as Exhibit "A".)

2. That on January 30, 1984, after this case was submitted to this Honorable Court for consideration, Justice

T. Eric Embry filed an action in the Circuit Court of Jefferson County, Alabama, which is styled as follows, *T. Eric Embry, etc. v. Blue Cross/Blue Shield of Alabama,* Civil Action No. CV-84-500-447, and which is still pending in the Jefferson County Circuit Court. (See a copy of said suit which is attached hereto and marked as Exhibit "B".)

3. In the Circuit Court of Jefferson County lawsuit against Blue Cross/Blue Shield, Justice T. Eric Embry alleges on behalf of himself and on behalf of a class of all state employees, among other things, that the failure of the defendant insurance company to pay a portion of his medical and hospital claim and delays in the payment of his claim by the defendant insurance company were committed in bad faith. In the District Court of Jefferson County lawsuit, Justice T. Eric Embry, individually, alleged that the defendant insurer in bad faith refused to pay his claim. Both cases demanded the imposition of punitive damages against the respective defendant insurers.

4. On February 14, 1985 and/or February 15, 1985, the appellant, through its attorneys, was made aware that Justice T. Eric Embry was a party plaintiff in the suits alleging bad faith. (See attached Affidavit Exhibit "C".)

5. Under the *Alabama Canons of Judicial Ethics,* Canon 3.C(1)(d)(ii), a Judge should disqualify himself in a proceeding in which his impartiality might reasonably be questioned if the Judge has an interest that could be substantially affected by the outcome of the proceeding. Further, the law of Alabama, as set forth in the attached brief, clearly mandates that Justice T. Eric Embry was disqualified from considering and participating in this case and that each Justice of this Court is also disqualified.

6. Each Justice of this Court participated in the Opinion of December 7, 1984, and may have an interest as a possible class member plaintiff in the Circuit Court action filed by Justice T. Eric Embry and as such has an interest that could be substantially affected by the outcome of this case.

7. The opinion issued by this Court on December 7, 1984, unless withdrawn, will substantially alter the law of the State of Alabama in several regards, including but not limited to, partial payment in bad faith cases, evidence regarding the wealth or poverty of parties, the imposition of punitive damages, the weight to be given the testimony of expert witnesses, and the "ordinary" bad faith case, in such a way as to affect the substantive Alabama law governing the class action filed by Justice T. Eric Embry in the Circuit Court of Jefferson County.

8. The failure of the Justices of this Court to disqualify themselves will cause the appellant to be deprived of property in violation of the Due Process Clause of the Fourteenth Amendment of the Federal Constitution.

9. Appellant, Aetna Life Insurance Company, contends now and, upon hearing of this case *de novo* as required by the Due Process Clause of the Fourteenth Amendment of the Federal Constitution, will contend:

(a). That the imposition of punitive damages on the appellant, Aetna Life Insurance Company, is violative of The Contracts Clause, Article 1, § 10, Clause 2 of the Federal Constitution in that the contract of insurance in this matter was entered into prior to Alabama's recognition of a right to recover punitive damages in an action for bad faith refusal to pay an insurance claim.

(b). That the $3,500,000.00 punitive damages award in this case is unconstitutional under the Excessive Fine Clause of the Eighth Amendment as incorporated by the Due Process Clause of the Fourteenth Amendment to the Federal Constitution.

(c). That the $3,500,000.00 punitive damages awarded in this case is an unconstitutional deprivation of property under the Due Process Clause of the Fourteenth Amendment to the Federal Constitution because, *inter alia*, it was

imposed pursuant to no standards and vests excessive discretion in the jury.

(d). That the imposition of a ten percent (10%) penalty imposed under § 12-22-72, *Code of Alabama, 1975,* is facially and, as applied, unconstitutional under the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the Federal Constitution.

10. Due to the disqualification of Justice T. Eric Embry and all the Justices of this Court, the Court must withdraw its opinion of December 7, 1984, for the Clerk of the Supreme Court to certify these disqualifications to the Governor of the State of Alabama, and for the special court to reconsider *de novo* this case in its entirety, as required by the Due Process Clause of the Fourteenth Amendment to the Federal Constitution.

11. The undersigned attorneys are duly and legally admitted to practice law by the Supreme Court of Alabama, are now attorneys in good standing of the Bar of this Court and hereby certify that this motion is filed in good faith and is filed because the undersigned have an obligation to the court as well as to our client. We owe the public a duty to aid the administration of justice, to uphold the dignity of the court and to respect its authority.

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, AL 36609

By: /s/ PETER V. SINTZ
Peter V. Sintz

By: /s/ WILLIAM M. CUNNINGHAM, JR.
William M. Cunningham, Jr.

CERTIFICATE OF SERVICE

I hereby certify that I have this 21st day of February 1985, served a copy of the above and foregoing pleading upon counsel for all parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

/s/ William M. Cunningham, Jr.
William M. Cunningham, Jr.

IN THE DISTRICT COURT OF JEFFERSON COUNTY, ALABAMA

Civil Action No. DV8400963

T. ERIC EMBRY, *Plaintiff*

v.

MARYLAND CASUALTY COMPANY, *Defendant*

COMPLAINT

[Filed Jan. 19, 1984. District Court of Jefferson County Civil Division]

A. During 1983, plaintiff and defendant entered into a homeowner's insurance policy contract, Policy No. THO-48494058 covering the household effects and personal property of the plaintiff and his wife, Bedford Embry, at their house at 3609 Springhill Road, Birmingham, Alabama. There was a champagne mink coat valued at $2,000 listed on a schedule of covered property in the said homeowner's insurance policy. Defendant agreed to pay to plaintiff the replacement value of that said mink coat scheduled on that insurance policy should it be lost, damaged, or stolen.

B. On to-wit, November 23, 1983, plaintiff gave notice to defendant that the said mink coat was lost or stolen and demanded payment of the replacement value as shown in the said insurance contract. The defendant gave no response.

C. Sometime immediately prior to Christmas 1983, plaintiff called the defendant to inquire about the status of his claim for the mink coat. Defendant informed plaintiff that it had the claim and was processing it, presumably for payment, and that defendant would notify plaintiff within the next week or so.

D. The defendant has failed to respond whatsoever to plaintiff's claims for payment of the replacement value of

the said fur which is due to be paid under the insurance contract mentioned above.

COUNT ONE

1. Plaintiff hereby adopts herein all of the previous paragraphs set forth above.

2. Plaintiff claims $2,000 damages from defendant for breach of the above mentioned insurance contract between plaintiff and defendant.

WHEREFORE, plaintiff demands judgment against defendant in the amount of Two Thousand Dollars ($2,000.00).

COUNT TWO

1. Plaintiff hereby adopts herein by reference all of the allegations in paragraphs A through D.

2. Plaintiff avers that defendant in bad faith, willfully, intentionally, and/or maliciously failed to pay a valid claim under the aforementioned insurance contract without lawful excuse. Plaintiff claims $3,000 damages for defendant's bad faith failure to pay a valid claim. Plaintiff claims punitive damages.

WHEREFORE, plaintiff demands judgment against defendant in the sum of Three Thousand Dollars ($3,000.00).

SIROTE, PERMUTT, FRIEND, FRIEDMAN, HELD & APOLINSKY, P.A.

By: /s/ C. LEE REEVES
C. Lee Reeves
P. O. Box 55727
Birmingham, Alabama 35255
(205) 933-7111

PLAINTIFF'S ADDRESS:

3609 Springhill Road
Birmingham, Alabama 35233

PLEASE SERVE DEFENDANT AS FOLLOWS:

Maryland Casualty Company
940 Montclair Road
Birmingham, Alabama 35213

[SEAL] I hereby certify that this is a true and correct copy. This the 20th of Feb. 1985,

/s/ POLLY CONRADI, Clerk*

---

* The Case Action Summary—Civil, and Fee Sheet (Civil) attached to this exhibit as filed in the Supreme Court of Alabama will be lodged with the Clerk of the Supreme Court of the United States simultaneously with filing this Jurisdictional Statement.

Exhibit "B"

IN THE CIRCUIT COURT FOR THE
TENTH JUDICIAL CIRCUIT
JEFFERSON COUNTY, ALABAMA

Civil Action No. 500 447

T. ERIC EMBRY, *Plaintiff, on behalf of himself and all other persons who are members of the Alabama State Employees Health Insurance Plan carrying medical and hospitalization insurance through Blue Cross/Blue Shield of Alabama, Group Policy Number 1300,*

v.

BLUE CROSS/BLUE SHIELD OF ALABAMA, *Defendant*

COMPLAINT

[Filed in Office, '84 Jan. 30, P4:17. D. L. Cockrell, Register]

Parties

1. Plaintiff, T. Eric Embry, is an adult resident citizen of Jefferson County, Alabama.

2. The defendant, Blue Cross/Blue Shield of Alabama is a corporation organized and existing under and by virtue of the laws of the State of Alabama with its principal place of business in Jefferson County, Alabama.

Factual Allegations

3. On to wit: 1 October, 1982, plaintiff, T. Eric Embry, was enrolled as a member of the Alabama State Employees Health Insurance Plan, a plan under which he and his dependent wife, Bedford Stall Embry (deceased as of 20 September, 1983) were insured against monetary losses resulting from Hospital-Surgical-Medical and Major Medi-

cal expenses subject to all the terms and conditions and limitations of a master contract between the State of Alabama and Blue Cross/Blue Shield of Alabama as Administrator of the plan. That contract is commonly known and referred to as Group Number 13000 by said Administrator. The Plaintiff and his wife were insured under the Plan, having contract number 418122167. From and after 1 October, 1982 to the date of the filing of this complaint plaintiff has remained insured under the said Plan and the premiums have been paid and continue to be paid on behalf of the Plaintiff by the State of Alabama as a part of the benefits of his employment by the State. Premiums for dependent coverage under said plan for Plaintiff's late wife were paid monthly, from 1 October, 1982 through 20 September, 1983 by the Plaintiff.

Pursuant to Rule 23 of the Alabama Rules of Civil Procedure, this action is brought on behalf of the Plaintiff, T. Eric Embry, and all other persons who are members of the Alabama State Employees Health Insurance Plan carrying medical and hospitalization insurance through Blue Cross/Blue Shield of Alabama, Group Policy Number 13000.

Class Action Allegations

4. The Plaintiff avers, on information and belief, as follows:

a) That the members of the class as defined in the preceding paragraph are so numerous that joinder of all members is impractical.

b) That there are hundreds of persons who are members of the class as defined hereinabove.

c) That there are questions of law and fact common to the said class.

d) That the said questions of law and fact common to the members of the said class include, but are not limited to, the following:

i) Whether the defendant, Blue Cross/Blue Shield of Alabama has in effect a master contract of medical and hospitalization insurance with the State of Alabama whereby employees of the State of Alabama and their enrolled dependents are insured against monetary losses resulting from certain medical and hospital expenses.

ii) Whether or not the defendant, Blue Cross/Blue Shield of Alabama, has a policy or custom of unreasonably delaying payment of valid claims made by insureds under the said group policy.

iii) Whether the defendant, Blue Cross/Blue Shield of Alabama, has a policy or practice of paying to medical providers only such amount or amounts as Blue Cross/Blue Shield unilaterally deems to be "reasonable" for the particular service, charge or procedure, regardless of what the provider may actually charge.

iv) Whether the defendant, Blue Cross/Blue Shield of Alabama, charges insurance premiums to the Alabama State Employees Health Insurance plan based on the actual charges of medical providers for their services, medical procedures, and medical treatment.

v) Whether the defendant, Blue Cross/Blue Shield of Alabama, charges premiums to the Alabama State Employees Health Insurance Plan, for Group Policy Number 13000, the cost of which is based on the actual charges of medical providers for their services, treatment and procedures, while simultaneously refusing to pay to those medical providers the amount of any actual charge which exceeds that which the defendant, in its unilateral opinion, deems "reasonable".

e) The claims of Plaintiff are typical of the claims of the said class.

f) Plaintiff will fairly and adequately represent the interests of said class.

g) Prosecution of separate actions by individual members of said class would create a risk of:

i) Inconsistent or varying adjudications with respect to individual members of the class sued for which would establish incompatible standards of conduct for the defendant; and

ii) Adjudications with respect to individual members of the class sued for, which would as a practical matter, because of the applicable statutes of limitation, and because of the expense of trial, depositions and other discovery procedures, be dispositive of the interests of other member of the class sued for, not parties to the adjudications, or substantially impair or impede their ability to protect their interests.

h) The acts of the defendant alleged in this complaint are wrongs against each and every member of said class sued for herein, on the grounds generally applicable to the said class and each member thereof, making appropriate declaratory relief with respect to the class sued for as a whole.

i) The actions of the defendant as set forth hereinabove were all pursuant to a common course of conduct, custom or policy of the defendant which operated as a breach of contract and a breach of duty to the plaintiff and others similarly situated.

j) The questions of law and fact common to the members of the class sued for here predominate over any questions affecting only individual members.

k) Permitting a class action herein is and will be superior to other available methods for the adjudication of controversies and claims set out herein between members of the class sued for and the defendants herein.

Factual Allegations

Plaintiff avers that he is an employee of the State of Alabama. On to wit: October 1, 1982, the plaintiff, T. Eric Embry, was enrolled as a member of the Alabama State Employees Health Insurance Plan, a plan under which he and his dependent wife, Bedford Stall Embry (deceased as of September 20, 1983) were insured against monetary losses resulting from Hospital-Surgical-Medical and Major Medical expenses subject to all the terms and conditions and limitations of a master contract between the State of Alabama and Blue Cross/Blue Shield of Alabama as Administrator of the plan. That master contract is known as Group Policy Number 13000. Plaintiff and his wife were insured pursuant to the said plan, having contract Number 418122167. From and after October 1, 1982 to the date of the filing of this complaint, Plaintiff has remained insured under the said Plan and the premiums paid and continue to be paid on behalf of the Plaintiff by the State of Alabama as a part of the benefits of his employment by the State. Premiums for the dependent coverage under said Plan for Plaintiff's late wife were paid monthly, from October 1, 1982 through the date of her death, September 20, 1983, by the Plaintiff.

5. Plaintiff claims that during and throughout the period October 1, 1982 to the date of filing of this complaint, the plaintiff and his wife, now deceased, underwent numerous medical procedures, incurred various expenses for medical treatments, medications, and other medical and surgical treatment. During and throughout the period October 1, 1982 to the date of the filing of this complaint, Plaintiff has filed with defendant, pursuant to the terms of said

policy, numerous claims for payment relating to medical treatment, doctors and hospital charges, and other covered expenses on behalf on of both himself and his spouse, now deceased.

6. Plaintiff avers that during the period October 1, 1982 through the time of filing of this complaint, the defendant has willfully and intentionally and fraudulently, as a part of the deliberate plan or scheme, (a) failed to pay many claims of the plaintiff from funds available to it, or in the custody or control from the Alabama State Employees Health Insurance Plan Fund, and further,

(b) in many instances, if the defendant did pay a claim at all, it did not pay the claim in full and failed and refused to pay the said claim in full and further,

(c) in many instances, if the defendant did pay the claim at all, in whole or in part, it paid the claim in a very late and untimely manner and only after unreasonable delay.

(d) Plaintiff further avers that the defendant, Blue Cross/Blue Shield of Alabama, as a conscious, willful and intentional and fraudulent plan or scheme, as withheld payment of valid claims for unreasonable lengths of time and in so doing, unlawfully enriched itself by investment of the money wrongfully withheld by it. Plaintiff avers that the said actions of defendand as set forth hereinabove of unreasonably delaying payment of valid claims and failure to pay valid claims in full within a reasonable time has injured the Plaintiff and others similarly situated, has caused the plaintiff and others similarly situated to suffer embarrassment and humiliation by being unable to promptly pay doctors, hospitals, pharmacies, and other medical services.

7. Plaintiff further avers that the defendant, Blue Cross/Blue Shield of Alabama, has a master contract with the Alabama State Employees Health Insurance Plan, to wit,

Group Number 13000. Plaintiff avers that the defendant, Blue Cross/Blue Shield of Alabama, has charged premiums to the State of Alabama, through the Alabama State Employees Health Insurance Plan, based upon the actual charges made by health care providers for the various services, treatment and supplies charged by those providers. Plaintiff further avers that even though the defendant, Blue Cross/Blue Shield of Alabama, bases its premium charge to the Alabama State Employees Health Insurance Plan on the actual charges of medical providers for their various services, that Blue Cross/Blue Shield of Alabama has a policy or custom of paying to medical providers only those charges for various medical services which the defendant, in its unilateral discretion, has deemed to be "reasonable", regardless of the actual charges of the provider. Plaintiff avers that the aforesaid conduct of the defendant has proximately resulted in the Alabama State Employees Health Insurance Plan paying excessive charges to the defendant and causing the said Plan to pay excessively high premiums on behalf of the employees of the State of Alabama and causing these employees, including the plaintiff, who carry dependent coverage pursuant to the said policy, to pay excessively high premiums for the medical insurance coverage.

8. Plaintiff avers that the defendant has acted in bad faith in its breach of the master contract, Group Number 13000, with the Alabama State Employees Health Insurance Plan.

Causes of Action

Count I

9. Plaintiff hereby adopts and incorporates by reference each and every allegation of the preceding paragraph as if fully set out herein.

10. Plaintiff avers that the defendant has breached an agreement with Plaintiff and other members of the class by:

a) Failing to pay valid claims of plaintiff and those of other members of the said class pursuant to the terms of the master contract between defendant and the State of Alabama;

b) Failing to pay valid claims of the plaintiff and those of other members of the class in full;

c) Failing to pay the claims of the plaintiff and those of other members of the class within a reasonable time and in delaying payment of valid claims for an unreasonable length of time.

(d) Charging premiums to the State of Alabama based on the actual charges of medical providers while maintaining a policy of paying only a portion of those actual charges to health care providers.

3. Plaintiff avers that as a direct and proximate result of the allegations as set forth hereinabove, plaintiff, and others have been injured and damaged and that the Alabama State Employees Health Insurance Fund has been injured and damaged.

Count II

11. Plaintiff hereby adopts and incorporates by reference each and every allegation of the preceding paragraphs as if fully set out herein.

12. Plaintiff avers that there is no lawful basis for the actions of defendant, to wit, in

(a) Refusing to pay valid claims of the plaintiff, and those of other members of the class;

(b) Refusing to pay in full valid claims of the plaintiff and those of other members of the class;

(c) Refusing to pay valid claims of the plaintiff and other members of the class in a timely manner.

(d) Having a policy or custom of failing and refusing to pay valid claims submitted to it under Group Policy 13000, refusing and failing to pay claims submitted under Group Policy 13000 in full, and in refusing to pay valid claims under Group Policy 13000 in a timely manner and in making any payments that are Tmade in whole or in part, only after unreasonable delay. The plaintiff further avers that the defendant, its agents and employees, knew and have known that there is no lawful basis for refusing or failing to pay the valid claims of plaintiff and other members of the class within a reasonable time pursuant to the said group policy; that the defendant, its agents and employees, knew that there was no lawful basis for refusing or failing to pay the claims of plaintiff and those other members of the class herein in full; and further, that the defendant, its agents and employees knew and have known that there is no lawful basis for refusing or failing to pay plaintiff's claims and those submitted by other members of the class herein.

(e) Having a policy or custom of charging premiums to the State of Alabama for Group Policy 13000 based on the actual charges of health care provided while intentionally paying claims, when or if they are paid at all, only in an amount deemed "reasonable" by defendant and paying in claims only a portion of the said actual charges.

13. Plaintiff avers that the defendant has committed the tort of bad faith in its dealings with the plaintiffs and with other members of the class as defined hereinabove. Plaintiff further avers that the defendant has acted in bad in failing and refusing to pay to plaintiff and other members of the class the benefits to which they are entitled pursuant to the insurance policy or contract, by refusing to pay valid claims in a timely manner, by refusing pay

valid claims in full, and in exercising a policy or course of conduct whereby it refuses to pay valid claims, in whole or in part, submitted by members of the class herein and when it does pay any claims, in whole or in part, pays them in such an unreasonably delayed fashion as to cause plaintiff herein and other members of the class great humiliation and embarrassment; and that as a direct and proximate result of the actions of defendant as set out hereinabove, plaintiff and other members of the class as defined hereinabove have been damaged and injured.

Relief Requested

Plaintiff prays that this Court will, as soon as practical, enter an order certifying this class as a class action pursuant to Rule 23, Alabama Rules of Civil Procedure.

a) Award to Plaintiff, and other members of the class herein, compensatory damage for breach of contract, inconvenience, emotional and mental distress, disappointment, pain and suffering.

b) That this court will award to plaintiff and other members of the class punitive damages for defendant's bad faith breach of contract;

c) That this court will award to plaintiff costs of this proceeding, a reasonable attorney's fee and such other and further relief as the court deems just and proper.

/s/ W. Eugene Rutledge
W. Eugene Rutledge
Attorney for Plaintiff

Of Counsel:

Rutledge and Associates
1300 Brown Marx Tower
2000 First Avenue North
Birmingham, Alabama 35203
Telephone: (205) 322-8761

Jury Demand

Plaintiff demands a trial by jury on all issues triable to a jury.

/s/ W. Eugene Rutledge
W. Eugene Rutledge

Plaintiff's Address

3609 Spring Hill Road
Birmingham, AL 35223

Serve Defendant At:

Blue Cross/Blue Shield of Alabama
c/o William Mandy, President
450 Riverchase Parkway, East
Birmingham, Alabama 35298

CIRCUIT COURT,
TENTH JUDICIAL CIRCUIT OF ALABAMA
IN EQUITY

THE STATE OF ALABAMA
JEFFERSON COUNTY

I, the undersigned, as Register of the Circuit Court, Tenth Judicial Circuit of Alabama, do hereby certify that the foregoing contains a full, true and correct copy of the instrument herewith set out as appears of record in said Court.

Witness my hand and seal of said Court, this the 15th day of February, 1985.

/s/ [Illegible], Register.
By: /s/ SUE WHITE, Deputy Register.

Exhibit "C"

STATE OF ALABAMA)
COUNTY OF MOBILE)

AFFIDAVIT

Personally appeared before me, the undersigned authority, this day came Peter V. Sintz and who after being first duly sworn does depose and say as follows:

My name is Peter V. Sintz and I am over the age of twenty-one years. I have been a licensed practicing attorney in Mobile, Alabama since September, 1967. I am one of the attorneys of record for Aetna Life Insurance Company in the case of Margaret Lavoie v. Aetna Life Insurance Company. On Thursday, February 14, 1985, I received a phone call from Mary Beth Mantiply, a practicing attorney in Mobile, Alabama, and formerly associated in the practice of law with our firm, informing me that Justice T. Eric Embry had pending and has pending a lawsuit alleging bad faith against Blue Cross/Blue Shield. I was informed that the suit was pending in the Circuit Court of Jefferson County. I called the Circuit Court clerk's office and learned that the lawsuit by Justice T. Eric Embry against Blue Cross/Blue Shield was filed on January 30, 1984. This was after the notice of appeal and briefs had been filed in Lavoie v. Aetna but before oral argument before the Supreme Court of Alabama. I learned that the defense attorney for Blue Cross/Blue Shield is William G. Sommerville, Jr., and I called and talked with him on February 14, 1985, and learned that the T. Eric Embry as Plaintiff is in fact Justice T. Eric Embry who participated in the oral argument and majority decision in Lavoie v. Aetna Life Insurance Company. My office then called the Aetna Life Insurance Company claim office in Birmingham, Alabama and asked them to obtain copies of the complaint filed by Justice Embry. It is attached to the

motion to recuse and set aside the opinion filed with this affidavit. We also learned that Justice Embry had filed a second lawsuit alleging bad faith on Friday, February 15, 1985, but that this lawsuit styled T. Eric Embry v. Maryland Casualty was filed on January 19, 1984, and had been dismissed on April 6, 1984. Until my telephone conversation of February 14, 1985, with Mary Beth Mantiply neither I, nor anyone representing Aetna Life Insurance Company had any knowledge of the pending active litigation alleging bad faith against an insurance carrier by Justice Embry until February 14, 1985. These lawsuits were never mentioned nor disclosed to us by Justice Embry or anyone else during the pendency of the appeal of Lavoie v. Aetna Life Insurance Company. In my opinion some of the legal issues in Justice Embry's pending lawsuit against Blue Cross/Blue Shield are the same or very similar to the legal issues raised in Lavoie v. Aetna Life Insurance Company.

/s/ PETER V. SINTZ
Peter V. Sintz

STATE OF ALABAMA)
COUNTY OF MOBILE)

Personally appeared before me, the undersigned authority, in and for said county and state, PETER V. SINTZ, who being by me first duly sworn does depose and say that he has read the foregoing affidavit and to the best of his knowledge the facts contained therein are true and correct.

/s/ PETER V. SINTZ
Peter V. Sintz

Subscribed and sworn to before me
this 21st, day of February, 1985.

/s/ MARY ANN HEYER
Notary Public

My Commission Expires 3-15-86

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

BRIEF IN SUPPORT OF MOTION FOR DISQUALIFICATION AND MOTION FOR WITHDRAWAL OF OPINION OF DECEMBER 7, 1984 AND FOR HEARING DE NOVO

PETER V. SINTZ
WILLIAM M. CUNNINGHAM, JR.
SINTZ, PIKE, CAMPBELL & DUKE
3763 Professional Parkway
Mobile, AL 36609

Attorneys for Appellant

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The Alabama Canons of Judicial Ethics, Canon 3C(1)(d)(ii) 4

STATEMENT OF THE CASE AND STATEMENT OF FACTS

This matter was tried in the Mobile County Circuit Court beginning on November 1, 1982. At the close of all the evidence, the case was submitted to the jury on two counts alleging breach of contract and bad faith. The jury returned a verdict in favor of the plaintiffs in the amount of $3,501,650.22.

After the post trial motions were denied by operation of law, defendant filed its notice of appeal on February 10, 1983. Briefs were submitted on behalf of both parties with the final reply brief being filed by the appellant on the 27th day of October, 1983. The Supreme Court denied oral argument on the 17th day of November, 1983 and the case was submitted to the Court. The court set aside the denial for oral argument on April 4, 1984 and oral argument was held on May 14, 1984. The court's opinion was issued on December 7, 1984 and the appellant timely filed an application for rehearing on December 28, 1984.

On February 14, 1985, the defendant, Aetna Life Insurance Company, discovered that Justice T. Eric Embry, as plaintiff, had pending at the time of oral arguments and the drafting of the opinion, a lawsuit in the Circuit Court of Jefferson County against Blue Cross/Blue Shield of Alabama, which alleges bad faith failure to pay insurance claims which was filed on January 30, 1984. This suit also purports to be a class action on behalf of all state employees insured under group plan number 1300, issued by Blue Cross/Blue Shield, as well as Justice Embry's personal claim for damages for bad faith refusal to pay. (See attached Exhibit A.)

On February 15, 1985, the attorneys for the appellant, Aetna Life Insurance Company discovered a second lawsuit which had been filed by Justice T. Eric Embry, as plaintiff, in the District Court of Jefferson County, against

Maryland Casualty Insurance Co., which alleged bad faith and which was dismissed in April, 1982. (See attached Exhibit B.)

ISSUES

I.

WHETHER JUSTICE T. ERIC EMBRY IS DISQUALIFIED FROM SITTING IN JUDGMENT IN A CASE INVOLVING THE SAME OR SUBSTANTIALLY THE SAME ISSUES AS HIS PERSONAL BAD FAITH CASE?

§ 12-1-12, *Alabama Code, 1975,*

Bryce v. Burke, Probate Judge, 172 Ala. 219, 55 So. 635.

Ex parte, Cornwell, 144 Ala. 497, 30 So. 354 (1905).

Gill v. State, 61 Ala. 172.

Medlin v. Taylor, 101 Ala. 239, 13 So. 310 (1893).

Morgan County Commission v. Powell, 292, Ala. 300, 293 So.2d 830 (1974)

Pegues v. Baker, 110 Ala. 251

Rushing v. City of Georgianna, 361 So.2d 11 (1978).

Smith v. Pitts, 139 Ala. 152, 36 So. 20

The Alabama Canons of Judicial Ethics, Canon 3C(1)(c), *The Alabama Canons of Judicial Ethics,* Canon 3C(1)(d)(ii)

II.

WHETHER ALL JUSTICES OF THE SUPREME COURT ARE DISQUALIFIED FROM SITTING AS JUSTICES IN THIS CASE WHEN THEY MAY BE MEMBERS OF THE CLASS ALLEGED BY JUSTICE T. ERIC EMBRY IN THE CIRCUIT COURT OF JEFFERSON COUNTY LAWSUIT?

In re Murchison, 349 U.S. 133, 75 S. Ct. 623, 90 L.Ed 942

In re *White,* 53 Ala. App. 377, 300 So.2d 420 (1974).

Morgan County Commission v. Powell, 292, Ala. 300, 293 So.2d 830 (1974)

Offutt v. United States, 348 U.S. 11, 14, 75 S. Ct. 11, 13, 99 L.Ed 11.

State v. Aldridge, 212 Ala. 660, 103 So. 835 (1973)

Tumey v. State of Ohio, 273 U.S. 510, 532, 47 S. Ct. 437, 444 71 L.Ed. 749.

III.

WHETHER THE DISQUALIFICATIONS OF A JUSTICE OR JUSTICES SHOULD RESULT IN A WITHDRAWAL OF THE OPINION OF DECEMBER 7, 1984 AND A RESUBMITTAL OF THE CASE *DE NOVO?*

§ 12-1-14, *Alabama Code, 1975*

Ann. CAS, 1916 B, 372

Clouman v. Henderson, 59 Ala. 559

Coger v. Franklin, 79 Ala. 505

Garland v. State, 140 S.E. 2d 1 146 Ga. App. 756 (1969)

Gulf States Steel Co., v. Christison, 228 Ala. 62, 154 So. 565

Hayes v. Collier, 47 Ala. 726

Hine v. Hussey, 45 Ala. 496

Hutto v. Walker County, 185 Ala. 505, 511, 64 So. 313

Jeffersonian Pub. Co. v. Hilliard, 105 Ala. 576, 581, 17 So. 112;

King v. Ellis, 146 Ga. App. 157, 246 S.E. 2d 1, (1978).

Salm v. State, 89 Ala., 568 So. 66 (1890)

State v. Phillips, 33 So.2d 239.

Trawick's Heirs v. Trawick's Adm'rs., 67 Ala. 271

IV.

WHETHER THE FAILURE OF THE JUSTICES OF THIS COURT TO DISQUALIFY THEMSELVES WILL CAUSE THE APPELLANT TO BE DEPRIVED OF PROPERTY IN VIOLATION OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT OF THE FEDERAL CONSTITUTION.

In re Murchison, 349 U.S. 133, 75 S. Ct. 623, 90 L.Ed 942
Gibson v. Berryhill, 411 U.S. 564, 579 (1973

Offutt v. United States, 348 U.S. 11, 14, 75 S. Ct. 11, 13, 99 L.Ed 11.

Tumey v. State of Ohio, 273 U.S. 510, 532, 47 S. Ct. 437, 444 71 L.Ed. 749.

Withrow v. Larkin, 421 U.S. 35 46-47 (1975)

ARGUMENT

I.

Whether Justice T. Eric Embry Is Disqualified From Sitting In Judgment In A Case Involving The Same Or Substantially The Same Issues As His Personal Bad Faith Case?

Alabama has been a leader in the nation in the area of legal ethics. In 1887, Alabama drafted the first Code of Legal Ethics in the country which was adopted with minor changes by other states and by the American Bar Association. Recognizing its leadership role, the Supreme Court of Alabama formulated and established principles which govern the conduct of members of the judiciary in the *Canons of Judicial Ethics.* The *Code of Alabama* also speaks directly to judicial ethics in § 12-1-12, *Alabama Code, 1975,* regarding disqualification of Judges and states as follows:

> "No judge of any court shall sit in any case or proceeding in which he is interested or related to any party within the fourth degree of consanguinity or affinity or in which he has been of counsel or in which is called in question the validity of any judgment or judicial proceeding in which he was of counsel or the validity or construction of any instrument or paper prepared or signed by him as counsel or attorney, without the consent of the parties entered of record or put in writing if the court is not of record."

The disqualifications set forth in the statute are non-exclusive. One must look to the qualifications which the common law imposes and which still remain in full force and effect. Under the stern morality of the common law, a judge is required to be legally indifferent between the parties. *Gill v. State,* 61 Ala. 172.

The Alabama Supreme Court has addressed itself to the common law principles involving instances where a judge's

interest in a lawsuit is not pecuniary and is not covered by § 12-1-12.

> "A judge or justice may be without pecuniary interest which will be affected by the result of a suit pending before him, and yet he may be a party to, or have an interest in, a suit involving the same questions upon which he is required to pass judgment. The bias, in favor of the one party or the other, naturally resulting, is deemed by the common law a disqualification." *Pegues v. Baker,* 110 Ala. 251

Under this line of reasoning, the statutory causes of disqualification of the judge are not exclusive of the common law principle. This is the controlling precedent in Alabama law. *Rushing v. City of Georgianna,* 361 So.2d 11 (1978).

The Alabama Supreme Court in 1893 addressed the issue of whether a probate judge properly disqualified himself in an election contest where the judge's own election was being contested in another action in a circuit court on the same grounds specified in the statement of contest in question. *Medlin v. Taylor,* 101 Ala. 239, 13 So. 310 (1893). The court found that the judge not only had no pecuniary interest, but also that he had *no* interest whatsoever which might be affected by any possible determination of the issues involved in the matter before him. However, the court agreed with the probate judge's decision to disqualify himself under the doctrine of the common law since he had a personal interest in the questions involved in the contestation before him. The same principle of personal interest affects Justice Embry's ability to sit in this case.

If a judge has any interest, the probable and natural tendency of which is to create a bias in the mind of the judge for or against the party to the suit, that tendency is sufficient to disqualify him as a judge. *Exparte, Cornwell,* 144 Ala. 497, 30 So. 354 (1905).

In *Morgan County Commission v. Powell,* 292, Ala. 300, 293 So.2d 830 (1974), this court determined that one of the common law grounds disqualifing a judge is that a judge ought not act where, from interest or any other cause, he is supposed to be partial to one of the suitors. *Smith v. Pitts,* 139 Ala. 152, 36 So. 20 (1904); *Bryce v. Burke, Probate Judge,* 172 Ala. 219, 55 So. 635, (1911). Furthermore, the court in *Morgan County, supra,* stated that a judge should not act if he has any interest, the probable and natural tendency of which is to create a bias in the mind of a judge for or against a party to the suit. *Morgan County, supra,* at page 311. Justice Jones in his special concurring opinion sums up the necessity that the justice system be totally impartial to all parties appearing before it when he said:

> "Paramount to any system of justice is the total impartiality of the court which sits in judgment of any controversy. The appearance of fairness is virtually as important as is fairness itself. One of the essential ingredients of an effective judiciary is the high level of respect accorded it by the citizenry. Except for the impartiality of those who occupy the role of judge, both in act and appearance, the level of respect necessary to a strong and effective judiciary will fail. It is the essence of the system that any position of interest or bias is sufficient cause for disqualification of a judge, and the right to raise and insist upon the causes of disqualification must be zealously guarded. . ." Supra at 312.

Are the requisite high standards of conduct and respect of the judiciary fulfilled when a justice has the appearance of bias by filing two bad faith cases, one of which alleges that the defendant insurance company ". . . did not pay the claim in full. . ." and who then participates in this case which decided that despite Aetna's partial payment, the bad faith claim was properly submitted to the jury?

The Alabama Canons of Judicial Ethics, Canon 3C(1)(c), states:

"C. Disqualification:

(1) A judge should disqualify himself in a proceeding in which is disqualification is required by law or his impartiality might reasonably be questioned, including but not limited to instances where:

(c) He knows that he, individually or as a fiduciary . . . has a financial interest in the subject matter in controversy or in a party to the proceeding, or any other interest that could be substantially affected by the outcome of the proceeding; . . ."

Also, the Canons of Judicial Ethics in Canon 3C(1)(d)(ii) disqualifies a judge if he is known to have an interest that could be substantially affected by the outcome of the proceeding.

The high standards of judicial ethics in Alabama as reflected in § 12-1-12, *Code of Alabama,* (1975), the developed precedents adopting the principles of common law and the *Alabama Canons of Judicial Ethics* can lead to but one conclusion: that Justice Embry's participation in the decision making process of this Court, including his being a member of the majority opinion of December 7, 1984, mandates his disqualification in this case.

II.

Whether All Justices Of The Supreme Court Are Disqualified From Sitting As Justices In This Case When They May Be Members Of The Class Alleged By Justice T. Eric Embry In The Circuit Court Of Jefferson County Lawsuit?

While the other members of the Court are not known by the appellant to have an interest in the class action suit

filed by Justice Embry, if they are members of the Alabama State Employees Health Insurance Plan carrying medical and hospitalization insurance through Blue Cross/Blue Shield of Alabama, Group Policy Number 1300, there exists the appearance of bias, sufficient to cause their disqualification. *Morgan County, supra* (Justice Jones' special concurrence, page 311).

Another ground of disqualification of the remaining Justices is their participation in general conferences, possible reviews of opinions written by Justices before the published opinion of December 7, 1984, and possible fixed opinion as a result of their deliberations expressed either in the majority opinion or in the dissents.

The Alabama Court of Criminal Appeals addressed the issue of appearance of bias involving a circuit court judge who had expressed opinions on the bail he required of a criminal defendant by sending letters to the Justices of that court. *In re White,* 53 Ala. App. 377, 300 So.2d 420 (1974). In the *White* case, the court reaffirmed language in *State v. Aldridge,* 212 Ala. 660, 103 So. 835 (1925) emphasizing the importance of every individual charged with a crime being accorded a fair and impartial trial:

> " 'It is the right of every citizen to be tried by judges as impartial as the lot of humanity will admit.' This is but the expression of a well known rule of universal justice everywhere recognized * * *. It is one of the great principles of the common law, for which the people of England had struggled for ages, and which they ultimately succeeded in establishing against the strenuous efforts of a tyrannical government. We can have no higher authority than this for denouncing as illegal everything which interferes with the entire impartirality of every legal tribunal."

The *White* case, supra, also reviewed the U.S. Supreme Court's requirements of due process in the case of *In re*

Murchison, 349 U.S. 133, 75 S. Ct. 623, 90 L.Ed. 942, which concluded that a fair trial in a fair tribunal is a basic due process requirement.

In order to preserve the high standards of judicial ethics, the justices of this Court must disqualify themselves and allow this case to be referred to an impartial panel of judges who are not clothed with any appearance of bias and who would be wholly free, disinterested and independent.

III.

Whether The Disqualifications Of A Justice Or Justices Should Result In A Withdrawal Of The Opinion Of December 7, 1984 And A Resubmittal Of The Case *De Novo*?

This issue appears to be an issue of first impression in Alabama concerning an appellate written, published opinion. The court in Alabama has uniformly held that a judgment is not void on account of disqualification, but is voidable on direct attack on appeal or by a seasonable motion to set it aside. *Hine v. Hussey,* 45 Ala. 496; *Hayes v. Collier,* 47 Ala. 726; *Clouman v. Henderson,* 59 Ala. 559; *Trawick's Heirs v. Trawick's Adm'rs.,* 67 Ala. 271; *Coger v. Franklin,* 79 Ala. 505; *Jeffersonian Pub. Co. v. Hilliard,* 105 Ala. 576, 581, 17 So. 112; *Hutto v. Walker County,* 185 Ala. 505, 511, 64 So. 313, *Ann. CAS,* 1916 B, 372; *Gulf States Steel Co., v. Christison,* 228 Ala. 62, 154 So. 565; *State v. Phillips,* 33 So.2d 239.

While Alabama has not addressed the voidability of an appellate decision, case law dictates that if a disqualified judge issues any orders in a case, the entire case is improperly tainted and new proceedings should be given the parties.

The Court in *Salm v. State,* 89 Ala., 568 So. 66 (1890), found that a judge who was disqualified was incompetent to preside and to properly decline to preside should not

have made certain preliminary orders. In that case, the court reversed the conviction based upon the judge's improper issuance of preliminary orders due to his disqualification as well as on other bases. Since the disqualification in *Salms, supra* extended to preliminary matters, the disqualifications of the justices in this suit should extend to the entire Supreme Court's considerations and deliberations of this case, thus voiding the Opinion of December 7, 1984.

Our sister state of Georgia has addressed this issue and determined that a judge in ordering that a petition in disbarment proceedings be filed and in issuing a Rule NiSi directed to an attorney was performing a judicial act and inasmuch as the judge declared that he was disqualified, even though his disqualification was not announced and acted upon until after the Rule NiSi and order for service were signed, the announcement related back to the petition and the Rule NiSi and rendered them null and void. *Garland v. State,* 140 S.E. 2d 1 146 Ga. App. 756 (1969). More recently, the Georgia Court of Appeals also found that the fact of disqualification of a judge relating back to and rendering all orders or judicial acts taken by him void and null except as to administrative acts. *King v. Ellis,* 14 Ga. App. 157, 246 S.E. 2d 1, (1978).

This result is the only logical approach to the effect of the December 7, 1984 Opinion of this Court. That is, Justice Embry or any other member of the Court is disqualified, the Opinion should be withdrawn and the parties allowed to proceed before an impartial Court.

Should the court determine that it is disqualified to sit in judgment on the application for rehearing, a certificate should be issued by the Clerk of the Court to the Governor of the State of Alabama to appoint a special court to hear this case. § 12-2-14, *Code of Alabama, 1975.* This hearing by the special court should be a *de novo* hearing.

IV.

Whether The Failure Of The Justices Of This Court To Disqualify Themselves Will Cause The Appellant To Be Deprived Of Property In Violation Of The Due Process Clause Of The Fourteenth Amendment Of The Federal Constitution.

That appellant's rights under the Due Process Clause of the Fourteenth Amendment will be violated if its case is not heard and determined *de novo* by unbiased decision makers is well established. In *In re: Murchison,* 349 U.S. 133, 136 (1955), Justice Hugo Black, writing for the Supreme Court, stated:

> "A fair trial in a fair tribunal is a basic requirement of due process. Fairness of course requires an absence of actual bias in the trial of cases. But our system of law has always endeavored to prevent even the probability of unfairness. To this end, no man can be a judge in his own case and no man is permitted to try cases where he has an interest in the outcome. That interest cannot be defined with precision. Circumstances and relationships must be considered. This Court has said, however, that 'Every procedure which would offer a possible temptation to the average man as a judge * * * not to hold the balance nice, clear and true between the State and the accused, denies the latter due process of law.' *Tumey v. State of Ohio,* 273 U.S. 510, 532. Such a stringent rule may sometimes bar trial by judges who have no actual bias and who would do their very best to weigh the scales of justice equally between contending parties. But to perform its high function in the best way 'justice must satisfy the appearance of justice.' *Offutt v. United States,* 348 U.S. 11, 14."

This constitutional principle, recently reaffirmed by a unanimous Supreme Court in *Withrow v. Larkin,* 421 U.S. 35, 46-47 (1975), has even been applied by the Supreme

Court to adjudications before administrative agencies. See *Gibson v. Berryhill,* 411 U.S. 564, 579 (1973). There can be no doubt that this principle applied *a fortiori* to the proceedings of this Honorable Court and that this principle requires that Appellant's case be heard and determined *de novo.*

CONCLUSION OF RELIEF SOUGHT

The appellant, Aetna Life Insurance Company is requesting as stated in its motion that Justice T. Eric Embry disqualify himself from considering the Appellant's pending application for rehearing, that the remaining Justices of this Court disqualify themselves as Justices considering the appellant's pending application for rehearing, for this Honorable Court to withdraw its opinion of December 7, 1984, which affirmed the verdict of the trial court, for the Clerk of the Supreme Court to certify the disqualifications of the Justices to the Governor of the State of Alabama in accordance with § 12-2-14, *Code of Alabama, 1975,* and for the special court to hear this case *de novo.*

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for the Appellant
3763 Professional Parkway
Mobile, AL 36609

By: /s/ PETER V. SINTZ
Peter V. Sintz

By: /s/ WILLIAM M. CUNNINGHAM, JR.
William M. Cunningham, Jr.

CERTIFICATE OF SERVICE

I hereby certify that I have this 21st day of Feb. 1984, served a copy of the above and foregoing pleading upon counsel for all parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

/s/ WILLIAM M. CUNNINGHAM, JR.
William M. Cunningham, Jr.

REQUEST FOR ORAL ARGUMENT

The issues presented in this Motion For Disqualification And Motion For Withdrawal Of Opinion Of December 7, 1984 and For Hearing De Novo concern matters of first impression in the State of Alabama, have called to question the appearance of bias of all members of the Court, involve Federal Constitutional issues that affect these parties and the Alabama judicial system.

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

AMENDMENT TO MOTION FOR DISQUALIFICATION AND MOTION FOR WITHDRAWAL OF OPINION OF DECEMBER 7, 1984 AND FOR HEARING DE NOVO

COMES now the Appellant, AETNA LIFE INSURANCE COMPANY, and amends its Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984 and for Hearing De Novo by submitting the affidavits of Elsie Boros and George Heitz, which are attached hereto and marked as Exhibits "D" and "E" respectively.

RESPECTFULLY SUBMITTED.

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, Alabama 36609

By:
PETER V. SINTZ

By:
WILLIAM M. CUNNINGHAM, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have this 7th day of March 1985, served a copy of the above and foregoing pleading upon counsel for all parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

WILLIAM M. CUNNINGHAM, JR.

STATE OF CONNECTICUT)
COUNTY OF HARTFORD)

AFFIDAVIT

Personally appeared before me, the undersigned authority, this day came George R. Heitz and who after being first duly sworn does depose and say as follows:

My name is George R. Heitz and I am over the age of Twenty-One years. I am employed by the Aetna Life Insurance Company, of Hartford, Connecticut. My position is that of Legal Officer and in that capacity am knowledgeable of the Margaret Lavoie VS Aetna Life Insurance Company Lawsuit.

My first notice that Justice T. Eric Embry had filed a lawsuit against Blue Cross/Blue Shield on January 30, 1984 was by a tlelphone call from Mr. William M. Cunningham Jr., one of the attorneys with the firm of Sintz, Pike, Campbell & Duke, Mobile, Alabama engaged as the Defense Attorneys for Aetna Life Insurance Company in the Lavoie suit. This call was in the morning of February 15, 1985. Prior to that date I had no prior knowledge of the action by Justice T. Eric Embry against Blue Cross-Blue Shield or anyone else.

/s/ George R. Heitz
George R. Heitz, Legal Officer

Personally appeared before me, the undersigned authority, in and for said County and State, George R. Heitz, who being by me first duly sworn does depose and say that he has read the foregoing Affidavit and th the best of his knowledge the facts contained therein are true & correct.

Subscribed and Sworn to before me

this 6th day of March, 1985

/s/ Stephen Kushner
Notary Public

My Commission Expires Mar. 31, 1987

AETNA
EMPLOYEE BENEFITS DIVISION
Claim Department
Suite 600
No. 4 Metroplex Drive
P.O. Box 59180
Birmingham, Alabama 35259-9180

E. I. Boros
Manager
(205) 877-8416

State of Alabama, County of Jefferson

AFFIDAVIT

Personally appeared before me, the undersigned authority, this day came Elsie I. Boros and who after being first duly sworn does depose and say as follows:

I, Elsie I. Boros, am Manager of the Employee Benefit Claim Department. This department is responsible for all EBD claims in litigation against Aetna Life Insurance in Alabama, specifically is the handling office of Aetna Life Insurance Company for the lawsuit styled Lavoie vs. Aetna.

In my February 14, 1985 conversation with Mr. Cunningham, on that date was the first I had known of Justice Embry's suit and to the best of my knowledge, it is the first known that any employee had of Justice Embry's suit.

No one at our Home Office in Hartford, Connecticut had notified me of the lawsuit.

/s/ ELSIE I. BOROS
E. I. Boros, Manager

/s/ DARLENE R. JENKINS
Darlene R. Jenkins, Notary Public

My Commission Expires April 30, 1986

[SEAL] Subscribed and sworn to before me on this 6th day of March, 1985.

APPENDIX G

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

MOTION TO SUSPEND RULES AND MOTION FOR STAY OF EXECUTION OF JUDGMENT

COMES now the Appellant, AETNA LIFE INSURANCE COMPANY, and moves this Honorable Court in accordance with Rule 2(b), *Alabama Rules of Appellate Procedure,* to suspend the application of Rule 40, *Alabama Rules of Appellate Procedure,* and to grant the appellant leave to file the attached Second Application for Rehearing. Further, the appellant respectfully moves the Court for a stay of execution of its judgment pending the Court's determination of the Motion to Suspend Rules, or in the alternative, the appellant respectfully prays that this Court will advance the Motion to Suspend Rules on its docket so that it will be ruled upon prior to March 26, 1985. Should this Court deny the Motion to Suspend Rules, Appellant asks this Court to treat the Motion for Stay of Execution of Judgment as a Motion for Stay pending the timely filing by Appellant of a Jurisdictional Statement in the Supreme Court of the United States, such stay to continue until the disposition of this case by the Supreme Court of the United States in accordance with the rules of that Court. The attached affidavit of Stephen B. Middlebrooks is submitted in the event the Court denies the Motion to Suspend Rules. As grounds for said motion, the appellant states as follows:

1. That on March 20, 1985, the appellant, through the efforts of its attorneys, obtained a copy of the deposition of Justice T. Eric Embry in the lawsuit styled, *T. Eric Embry v. Blue Cross/Blue Shield of Alabama,* Civil Action No. CV-84-500-447, which action was filed in the Circuit Court of Jefferson County. (See attached affidavits marked as Exhibits 1 and 2 and attached letter marked at Exhibit 3)

2. That the testimony of Justice Embry in his deposition contains new evidence that this Court should consider with respect to Justice Embry's qualification to have participated and to continue to participate in the consideration and decision of the appellant's Motions, including appellant's Application for Rehearing, appellant's Motions filed in this Court on February 21, 1985, in this case, and these present Motions and Second Application for Rehearing. (Exhibit 4)

3. That a stay of the execution of the judgment pending final disposition of this Motion and the Second Application for Rehearing is necessary to prevent irreparable injury to Aetna Life Insurance Company should this Court's judgment in this case be reversed, and that a stay pending final disposition of a Jurisdictional Statement to be timely filed by appellant in the Supreme Court of the United States should this Court deny appellant's Motion to Suspend Rules or overrule appellant's Second Application for Rehearing is also necessary to prevent irreparable injury to appellant should this Court's judgment in this case be reversed. Conversely, the appellees' interests are fully protected by the supersedeas bond presently in effect and the additional supersedeas bond attached hereto and marked as Exhibit 5. The combined total of these bonds are in excess of ONE HUNDRED TWENTY-FIVE PERCENT (125%) of the total judgment, including interest and penalty.

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, Alabama 36609

Original Signed By:
By: Peter V. Sintz
PETER V. SINTZ

Original Signed By:
By: William M. Cunningham, Jr.
WILLIAM M. CUNNINGHAM, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have this 22nd day of March, 1985, served a copy of the above and foregoing pleading upon Joseph M. Brown, Jr., attorney for appellees, by hand delivering same and to all other parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

Original Signed By:
William M. Cunningham, Jr.
WILLIAM M. CUNNINGHAM, JR.

Honorable Joseph M. Brown, Jr.
Attorney at Law
1601 Dauphin Street
Mobile, AL 36660

Honorable Charles A. Graddick
Attorney General
250 Administrative Building
Montgomery, AL 36130

Honorable Edgar M. Elliott, III
Attorney at Law
1700 Financial Center
Birmingham, AL 35203

Honorable James T. Upchurch
Attorney at Law
Post Office Box 270
Montgomery, AL 36195

Honorable Thad Salmon
Attorney at Law
2108 East South Boulevard
Montgomery, AL 36111

Honorable Lanny Vines
Attorney at Law
1800 City Federal Bldg.
Birmingham, AL 35203

Honorable Harry Cole
Attorney at Law
Post Office Box 116
Montgomery, AL 36195

Exhibit One

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

AFFIDAVIT OF WILLIAM M. CUNNINGHAM, JR.

STATE OF ALABAMA
COUNTY OF MOBILE

Personally appeared before me, the undersigned authority in said State and County, WILLIAM M. CUNNINGHAM, JR., who after first being duly sworn by me doth depose and say as follows:

My name is William M. Cunningham, Jr., and I am one of the attorneys of record for Aetna Life Insurance Company in the above styled lawsuit.

On behalf of Aetna Life Insurance Company, I attempted to obtain a copy of the deposition of Justice T. Eric Embry, which was taken on January 10, 1985 in the following case: *T. Eric Embry v. Blue Cross/Blue Shield of Alabama,* Civil Action No. CV-84-500-447, which action was filed in the Circuit Court of Jefferson County. This office learned of Justice Embry's deposition on February 14, 1985. (See attached affidavit of Peter V. Sintz, marked as Exhibit "2")

On Monday, February 25, 1985, I made a telephone call to William G. Somerville, Jr., an attorney of record for Blue Cross/Blue Shield of Alabama in the lawsuit styled, *T. Eric Embry v. Blue Cross/Blue Shield of Alabama,* Civil Action No. CV-84-500-447. In that conversation, I asked Mr. Somerville if he had any objections to Aetna

Life Insurance Company obtaining a copy of the deposition of Justice Embry. Mr. Somerville advised me that he had no objections and that he would provide me with the name of the court reporter. I did not receive a return telephone call from Mr. Somerville that day advising me of the name of the court reporter.

I instructed my secretary to call Mr. Somerville's office the next day and learned then that the court reporter was Ms. Kathy Thames. I then instructed my secretary to call Ms. Thames and request a copy of the deposition. It was at this time that I learned that the deposition had not been transcribed, but that the per diem had been paid. At Ms. Thames' request, I authorized my secretary to advise Ms. Thames that we would pay for the transcription of the deposition in order that we might obtain a complete copy.

On Thursday, February 28, 1985, around 4:00 p.m., I was advised by my secretary that Ms. Thames could not provide us with a copy of the deposition. I then called Ms. Thames and she advised me that the secretary to Eugene Rutledge, attorney for the plaintiff in the *T. Eric Embry* lawsuit, had called her stating that no copy of the deposition could be provided to anyone and that Mr. Somerville had concurred in that request.

After this telephone conversation, I called Mr. Somerville and asked him if Justice Embry had mentioned the *Lavoie* case in his deposition. At that time, Mr. Somerville told me that Justice Embry had discussed the *Lavoie* case to some degree and that he could not agree to allowing us to obtain a copy of the deposition. He suggested that I discuss the problem with Mr. Rutledge.

I then sent a letter to Mr. Somerville by Zap Mail, a copy of which is attached hereto and marked as Exhibit "3".

Prior to dictating that letter, I attempted to call Mr. Rutledge to ask him if he would reconsider the instructions

his secretary had given the court reporter regarding the copies of the deposition. Mr. Rutledge was not in his office and was not to return until the following Monday. On the following Monday, which was March 4, 1985, I spoke to Mr. Rutledge, who advised me that he had no objections to our obtaining a copy of the deposition and that I could so instruct the court reporter. After talking to Mr. Rutledge, I called Mr. Somerville, who was not in, and advised his secretary that I had received permission from Mr. Rutledge to obtain a copy of the deposition and that if Mr. Somerville had any further objections, he should contact me immediately. I did not hear from Mr. Somerville.

I then called Ms. Thames and advised her that the objections to my obtaining the deposition by Mr. Rutledge's office had been released and requested that she please prepare me a copy of the deposition.

On March 8, 1985, the court overruled our application for rehearing and denied our motion for disqualification.

On March 20, 1985, the deposition was received in my office after being shipped by Ms. Thames to me on a bus lines, which was the fastest available means.

Prior to receiving the deposition on March 20, 1985, the only knowledge I had of the susbtance of the testimony of Justice Embry was Mr. Somerville's representations that Justice Embry had discussed the *Lavoie* case in the deposition.

FURTHER AFFIANT SAITH NOT.

/s/ William M. Cunningham, Jr.
William M. Cunningham, Jr.

Subscribed and sworn to before me on this 21st day of March, 1985.

/s/ Mary Ann Heyer
Notary Public

My Commission Expires 3-15-86

Exhibit Two

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

AFFIDAVIT OF PETER V. SINTZ

STATE OF ALABAMA
COUNTY OF MOBILE

Personally appeared before me, the undersigned authority in said State and County, PETER V. SINTZ, who after first being duly sworn by me doth depose and say as follows:

My name is Peter V. Sintz, and I am one of the attorneys of record for Aetna Life Insurance Company in the above styled lawsuit.

On February 14, 1985, after discovering that Justice T. Eric Embry had filed a bad faith lawsuit in Jefferson County, I called William G. Somerville, Jr., attorney of record for Blue Cross/Blue Shield of Alabama in that lawsuit and confirmed the existence of the suit. In that conversation, Mr. Somerville advised me that Justice T. Eric Embry's deposition had been taken and that in the deposition, Justice Embry memtioned the *Lavoie* case. He further advised me that the deposition had not been concluded and that it was continued generally, pending a possible settlement. Until I read portions of the deposition on March 20, 1985, I was not aware of the substance of Justice Embry's testimony.

FURTHER AFFIANT SAITH NOT.

/s/ Peter V. Sintz
Peter V. Sintz

Subscribed and sworn to before me on this 21st day of March, 1985.

/s/ Mary Ann Heyer
Notary Public

My Commission Expires 3-15-86

Exhibit Three

March 1, 1985

Zap Mail

Honorable William G. Somerville, Jr.
Attorney at Law
1700 1st Alabama Bank Bldg.
Birmingham, AL 35203-3272

Re: Embry v. Blue Cross/Blue Shield

Dear Bill:

This is to confirm my telephone conversation with you on February 28, 1985, around 5:45 p.m., wherein you advised me that you had no objection to the plaintiff's attorney's request that the transcript of Justice Embry not be released to anyone. Your reconsideration of this position is requested.

Around February 14, 1985, when we discovered that Justice Embry had filed a bad faith lawsuit in Jefferson County, my partner, Pete Sintz, called you to confirm the existence of that suit. In that conversation, you advised Pete that Justice Embry's deposition had been taken and that in the deposition the Justice mentioned the *Lavoie* case. On Monday, February 25, 1985, I spoke with you and asked if you had any objections to our obtaining a copy of the deposition. You replied, "No", and promised that you would provide me with the name of the court reporter.

My secretary called Ms. Kathy Thames on Tuesday and requested that a copy of the deposition be sent to us. Ms. Thames advised her that the deposition had not been transcribed, but that the per diem had been paid. She further advised us that we would have to pay for the original of the deposition since it had not been transcribed. After being advised of this, I authorized my secretary to order a complete copy and that we would pay any cost involved.

She called Ms. Thames and requested the deposition, advising her that we would pay the entire cost.

On Thursday, February 28, 1985, around 4:00 p.m., my secretary received a call from Ms. Thames advising that she could not provide us with a copy of the deposition. I called her and she told me that Gene Rutledge's secretary had called her stating that no copy of the deposition could be provided to anyone and that you concurred in that request.

Both, when Pete called you and when I spoke to you on Thursday afternoon, you stated that Justice Embry mentioned the *Lavoie* case in his deposition. We also discussed in our various conversations, our motion to disqualify Justice Embry from hearing the application for rehearing.

I am certain that you are aware of the seriousness of our motion, both to our client and to the judicial system. We must discover and consider all evidence that has an effect on our motion. Under Rule 31(f), an official (the court reporter) is to "promptly file" the deposition. There are also federal cases which speak to the fact that depositions are public records. Since depositions are to be filed and since depositions are part of the court record, you must agree that they are public records.

Our client has agreed to absorb all cost in the transcription of the deposition.

Since you originally had no objection to providing us with a copy, since we made the necessary arrangements to obtain the copy, and since the deposition is a public record, we must request that you reconsider your last decision and advise the court reporter to transcribe the deposition and provide us with a copy, or at least file it as required by 30(f)(1), Alabama Rules of Civil Procedure.

Due to the urgency of this matter, this letter is being sent to you by Federal Express Zap Mail and should arrive

before noon today. Please call me and advise me of your decision as soon as possible, so that we can advise our client of what action, if any, to take.

Sincerely yours,

WILLIAM M. CUNNINGHAM, JR.
For the Firm

WMCJr:ah
cc: George Heitz

Exhibit Four

[1] IN THE CIRCUIT COURT OF THE TENTH JUDICIAL CIRCUIT, IN AND FOR JEFFERSON COUNTY, ALABAMA

Civil Action No. CV-84-500-447-JDC

T. ERIC EMBRY, ET AL, *Plaintiff*,

VS.

BLUE CROSS/BLUE SHIELD OF ALABAMA, *Defendants*.

STIPULATION

IT IS STIPULATED AND AGREED, by and between the parties, through their respective counsel, that the deposition of T. ERIC EMBRY may be taken before Kathie Thames, Registered Professional Reporter, Commissioner and Notary Public, State at Large, at 1300 Brpwn-Marx Tower, Birmingham, Alabama, on the 10th day of January, 1985, commencing at 10:00 A.M.

IT IS FURTHER STIPULATED AND AGREED that the signature to and reading of the [2] deposition by the witness is waived, the deposition to have the same force and effect as if full compliance had been had with all laws and rules of Court relating to the taking of depositions.

IT IS FURTHER STIPULATED AND AGREED that it shall not be necessary for any objections to be made by counsel to any questions, except as to form or leading questions, and that counsel for the parties may make objections and assign grounds at the time of trial, or at the time said deposition is offered in evidence, or prior thereto.

IT IS FURTHER STIPULATED AND AGREED that notice of filing of the deposition by the Commissioner is waived.

[3]

APPEARANCES

FOR THE PLAINTIFF:

Mr. W. Eugene Rutledge
Attorney at Law
Rutledge, Kay & Kelly
1300 Brown-Marx Tower
Birmingham, Alabama 35203

FOR THE DEFENDANT:

Messrs. Henry E. Simpson
and William G. Somerville, Jr.
Attorneys at Law
Lange, Simpson, Robinson & Somerville
17th Floor
First Alabama Bank Building
Birmingham, Alabama 35203

ALSO PRESENT:

Pam Blalock
Gray Till

[4] I, Kathie Thames, a Registered Professional Reporter of Birmingham, Alabama, and a Notary Public for the State of Alabama at Large, acting as Commissioner, certify that on this date, pursuant to Rule 30 of the Alabama Rules of Civil Procedure, and the foregoing stipulation of counsel, there came before me at 1300 Brown-Marx Tower, Birmingham, Alabama, commencing at 10:00 A.M., T. ERIC EMBRY, witness in the above cause, for oral examination, whereupon the following proceedings were had:

T. Eric Embry,

being first duly sworn, was examined and testified as follows:

EXAMINATION BY MR. SIMPSON:

Q. Judge, the court reporter has asked usual stipulations. Do you want to waive the signature or not?

MR. RUTLEDGE: Yeah, we waive.

Q. Give me your full name, age and address.

[5] A. My full name is Thomas Eric Embry, E-m-b-r-y, and I live at 3609 Springhill Road, one word, Birmingham 35223.

Q. Is your Social Security number 418-12-2167.

A. Yes.

Q. Would you give me your date of birth, please?

A. 6-14-21, June 14th.

Q. And your deceased wife's name was Bedford Stall Embry?

A. Right.

Q. And did she die on September the 20th?

A. 20th, '83, yeah, '83.

Q. Do you have any dependents presently?

A. Well, not legally.

Q. You had two daughters?

A. Yeah.

Q. Are those both grown?

A. Yeah. Thirty-seven and thirty respectively, and five grandchildren.

Q. In so far as your Blue Cross, state any type of insurance coverage?

[6] A. No dependents.

Q. Would that be true for the year commencing October of '82 also?

A. Yeah. No, '82 I had a wife living.

Q. Other than Mrs. Embry?

A. Yeah, right.

Q. You have produced certain things here pursuant to our notice of deposition and I have, maybe I ought to ask counsel, are these extra copies?

MR. RUTLEDGE: Yes. Those are yours.

Q. As far as the tax returns?

A. I got all I could find.

MR. RUTLEDGE: Are those different years. Hand me one copy.

Q. You have produced a portion of your '83 and your '82 and your '81 federal and '79 and '78 federal tax returns?

A. And '80 I couldn't find.

Q. Maybe we just ought to have this group of documents.

(Whereupon, Defendant's Exhibit 1 was marked for identification).

[7] Q. Looking at Defendant's Exhibit 1 if your counsel will let you look at it with him over there, as I understand the term, you took no deductions for medical expenses in 1983, is that correct?

A. I don't really know because these things are prepared for me by Kenneth Carnethan, accountant, and he usually just questions me and he decides whether to deduct or not, so whatever it shows on the return is what I did.

Q. I presume you sign your returns?

A. Yeah, sign them.

Q. And if you would look there with me so we can eliminate this issue. On your 1983 return, does it, on line seven does it shown a zero deduction?

A. Schedule 8-A?

Q. Yes.

A. Zero.

Q. And according to your understanding would that be where you would show a deduction for medical expenses if one had been taken, was your answer in the affirmative?

[8] A. Yes.

Q. Now, if you would, turn to 1982.

A. Okay.

Q. And at that time you show in that same position, although it's numbered differently on the '82 form you show one hundred fifty dollars deduction?

A. Line ten, schedule A, correct.

Q. Does that represent the allowable amount of deduction for hospital insurance, is that the origin of that deduction?

A. No. As I recall it, of course, I say I rely on them on the tax part, it's the amount that was expended in excess of certain percentage of gross income, as I understand it.

Q. All right, sir. Then look at the schedule that accompanied your '82 return for itemized deductions for medical and dental expense.

A. Okay. Medicines and drugs?

Q. Yes.

A. On one twenty-four sixty-eight fifty-five. I don't know what this is, federal [9] one percent.

MR. RUTLEDGE: That is the computation.

Q. That is the computation based on your gross adjusted income, is that what line two is, is that your understanding?

A. I guess so. I don't really understand it. I ain't much on mathematics or taxes.

Q. And then on line four there is a figure of eight hundred sixty-two dollars and sixteen cents under total insurance premium paid for medical and dental care?

A. That is the dependent's coverage under the Blue Cross state employees.

Q. Is there any other cost in there?

A. Yeah, there was a policy, I still have, with American Family Life in Columbus, Georgia, cancer policy. I think that was seven dollars a month, I believe, at that time. I'm just guessing at that because I get those figures from our clerk's office and turn them over to the accountant.

[10] Q. Was there any other insurance premium that you can recall?

A. Not medical.

Q. So that eight hundred sixty-two dollars and sixteen cents, according to your best recollection.

A. That is Blue Cross and American Family Life.

Q. Do you remember the dependant's monthly premium cost for the state plan at that time?

A. No, the clerk would give me a slip of paper, Mrs. Barnes keeps the books for the court for that yearly and I would turn it over to him. She showed so much a month, so many months, it's currently one hundred fifty-six dollars, but it wasn't that much in '82.

Q. What, was that deducted from your check?

A. Yeah, part of those deductions for pension and whatever, withholding tax.

Q. Have you kept your—the check stubs?

A. I got check stubs going back down [11] to——

Q. Checks payable to you that were itemized deductions from your check?

A. Oh, no. I think my secretary may have those vouchers. No, I don't have them.

Q. Now, the fourth line there is what we just discussed?

A. Right.

Q. And you have, in line five you have put down five hundred and thirty-one dollars for doctors, dentists and hospitals. Was that the total amount of expenditures that you deducted for 1982?

A. The work sheets are with the accountant. I don't know what it represents.

Q. Is it your understanding that that was the total amount?

A. He computed it, so I suppose it's accurate.

Q. Then there is a deduction from those totals entitled medical reimbursement, one thousand eight hundred ninety dollars and sixty-four cents. Do you know the origin of [12] that figure?

A. Yeah.

Q. What is that?

A. It's from Blue Cross for major medical claims for prescription medicines and certain portions of doctors bills.

Q. All right. Can you tell me, Mr. Embry, is that amount of money that you received back personally or was that an

amount of money that is composed partially of payments made by Blue Cross on your behalf to provide——

A. No, that would be money that came to me by check that I would enter on the bottom part of the check from Blue Cross, they have a thing showing what it went for, what to reimburse you for and I would put income on that and turn it over to the accountant.

Q. Let me, if I may, go back to item one then.

A. Okay.

Q. Is it your understanding of the two thousand four hundred sixty-eight dollars and fifty-five cent figure that that includes the [13] total amount that was expended by you and on your behalf or on your wife's behalf for medicines and drugs?

A. No.

Q. That was simply the amount?

A. What I had a record of.

Q. Let me ask you, what I'm trying to get at, is that the amount that you had to pay separate and apart from any sums that were paid directly by Blue Cross?

A. Right.

Q. So that two thousand four hundred sixty-eight dollars—Mr. Rutledge wants to speak to you.

(Off-the-record discussion.)

Q. On the record. I wanted to ask you, I think you remarked to Mr. Rutledge, you said that your wife's cancer was diagnosed in March of '83?

A. Yeah.

Q. Do you know what doctor made that diagnosis?

A. Yeah. Well, initially out at [14] Brookwood Hospital, a young Dr. Blanton, his partner, Jimmy Buschnell had put her in there. She was bleeding from the nose and throat. We thought, I may be corrected, that it was due to all the medication she had taken over the years, those blood vessels being brittle. But this diagnosis, I took her out of Brookwood and Dr. O. W. Clayton did a biopsy on her at Baptist Montclair and Dr. William Howley took over the chemotherapy and the radiation at Baptist Montclair.

Q. Did the cancer have any specific diagnosis?

A. Yeah, it was where the bronchial tube enters the lung.

Q. Let me call your attention to line five, five hundred thirty-one dollar figure, is that the amount for doctors, dentists and hospitals that you personally paid other than——

A. That is part of it.

Q. Well, does that include any sums which were paid on your behalf by Blue Cross or [15] any other insured?

A. No.

Q. On your 1981 return that also shows on schedule A one hundred fifty dollar deduction under line ten, does it not?

A. Here on the left hand side, yeah.

Q. And on the schedule it supports that you had supplied us for the year 1981 under line one you have one half of insurance premiums but not more than one hundred fifty dollars.

MR. RUTLEDGE: He is on the next page.

A. I see.

Q. That is the caption of line one and you have one hundred fifty dollars?

A. Well, that would be the maximum, I take it from the form.

Q. Right.

A. I don't recall, no.

Q. Do you know what insurance premiums that you had?

A. That would have been the same two I mentioned earlier, American Family Life and Blue Cross.

[16] Q. Was it, in other words, your dependant's payment?

A. Yeah. It would have to be that.

Q. Because——

A. That is the only medical insurance we had. Well, now, wait a minute, '81, I don't know whether I had the cancer policy, I probably did, but it was either one or both of American Family Life or Blue Cross.

Q. And would your answers concerning line two, the medicine and drug expense and line six, the other medical and dental expense be the same as it was for the year 1982?

A. Sure.

Q. In other words, those were amounts that you expended directly, not amounts that were expended on your behalf?

A. That is correct.

Q. And the reimbursement figure that is shown there, one thousand six hundred five dollars and nineteen cents would have been money received directly from you?

A. By me.

[17] Q. And you assumed from—and you assume from Blue Cross?

A. Had to be.

Q. You have on line 5-A, and the figure for insurance premiums, balance of seven hundred fifty dollars and eighty-four cents?

A. I don't know what that, if it says maximum was one hundred fifty what would premiums on five be, I don't know. The accountant may know. I don't understand that.

MR. RUTLEDGE: Well, you add one hundred fifty and do you want me to say?

A. I don't understand, but maybe y'all do. I don't know what the hell it is.

MR. RUTLEDGE: You add this figure to the seven hundred fifty figure and get it.

A. If you say so.

Q. Do you follow Mr. Rutledge's advice on all matters?

A. No, I don't understand this thing. I don't understand taxes so I never file on a return.

Q. Did you take the subject of taxation [18] when you were in law school?

A. Hell, no.

Q. Did you graduate from law school?

A. Yeah.

Q. I thought you went to the University of Alabama?

A. I did. I didn't take fool things like taxation, though. Let the folks with mathmatical bent minds do that.

Q. Look at your '79 return there.

A. Okay. They change the form every year, I guess.

Q. On schedule A of your '79 return which is denominated on that form schedules A and B——

A. Right.

Q. Under medical and dental expenses you have under line two a figure of medicine and drugs of one thousand six hundred eighteen dollars and eighteen cents. Is that your understanding of the——

A. That which I could verify.

Q. And would that have been medicine and [19] drug expense that you incurred directly for you and your wife rather than what was reimbursed?

A. Yeah.

Q. The same as for line six, the doctors and dentists, is that your understanding?

A. Right.

Q. And you show there reimbursed by insurance nine hundred eight dollars and eighty-seven cents?

A. Well, he's got a parentheses with a minus. I don't understand what the hell that means. I tell you, he is deducting that instead of showing it as income. He is deducting that, I suppose is what he did.

Q. And looking now to the form '78, the form seems to be the same as it was in '79. Was your understanding of the same figures?

A. Right.

Q. The same as it would be?

A. In those various itemized lines, I mean numbered lines.

Q. There does not appear to be a figure there for reimbursement from the insurance [20] company. Do you know whether—do you see it there?

A. I suppose, because, I could only guess as to why it didn't show up in '78.

Q. What would be your judgment?

A. That was in October, late October of that year was when I had sort of a heart attack or whatever you call it, and those claims didn't get filed and reimbursements made until the following year. I suppose that is the answer to it.

Q. Would those claims have been filed under the state plan as far as you know?

A. Yeah. Well, in Montgomery initially, the hospital there and they transferred me here by ambulance to University Hospital and I stayed there until right before Christmas. Then later during Christmas I went out to Beaumont, Texas to see doctor—oh, great big fellow, Joe Reeves.

Q. And you went to Texas to be treated?

A. Beaumont, yeah.

Q. Now, Judge, when did you become a [21] state employee?

A. The 20th day of January of 1975.

Q. And that is when you were elected to the court or that is when you took office?

A. That is when the term of my office began at 12:01 midnight.

Q. Were you ever a state employee prior to that time?

A. Well, when I was eight years old I was a page in the legislature.

Q. How much did you get paid?

A. I got paid the huge sum, and you better believe it was huge in 1931, fifty-four dollars every two weeks. I saved it all, too.

Q. Who appointed you as a page?

A. Finis St. John's grandfather from Cullman who had

no legs, but he had two wooden legs. He was a great friend of my mother, he put me on.

Q. Did you miss much school as a result of that?

A. No, mother had been a school teacher and she told the school system at Pell City that [22] she would keep me current so when I came home on the weekend she would make me do my damn lessons and turn in my homework. I didn't like it much, but that was the condition.

Q. Your father was at the legislature at that time?

A. No, he had been in the legislature in 1923 and he was lobbying, believe it or not, for Associated Industries.

Q. Anybody else?

A. Not that I know of. Had a great time.

Q. Other than that have you had any employment by the state?

A. No.

Q. Were you ever, before we had the passage in the judicial article, did you ever hold a county office?

A. No. When I was practicing law my daddy was county attorney, but that is not an office. St. Clair County.

Q. You were never deputy soliciter?

A. No, my father was. He had been circuit soliciter, but he resigned.

[23] Q. You have never been a judge of an inferior court?

A. No. This is the—unless it's the one I'm on. Some fellows have said it's inferior.

Q. Did Mr. Rutledge say that to you?

A. No, I don't think so, not in public.

MR. RUTLEDGE: Not outside the attorney/client privilege.

Q. Now, you have also produced here a—two folders?

A. I don't know what is there. I turned them over to Gene.

MR. RUTLEDGE: Those are not copies, so whatever you want out of that we'll be glad to copy for you.

A. They appear to be what, previous claims and communications from Blue Cross.

Q. Is this everything that you have that will——

A. Up to the date that that, and more of the same in my file over at UAB, but it doesn't, you know, it post dates the filling of the [24] lawsuit.

Q. All right. Let me——

MR. RUTLEDGE: You want me to run all that for you?

MR. SIMPSON: I'll let Bill Somerville look at it and he can decide on that.

Q. You have an office at UAB?

A. Yeah, yes, sir.

Q. What is that over there?

A. That is 9012 South 15th Street, Building Number 4, Room 101-A.

Q. Do you have a secretary in Birmingham?

A. No, I have a staff attorney here.

Q. Do you have any other residents, part-time residents other than the Springhill address?

A. No. I did have in Montgomery, but when my wife died I gave it up.

Q. And could you give me that address in Montgomery?

A. I was fearful you were going to ask that. Two hundred and something South Bainbridge Street, Apartment Number 1. Half of [25] an old house. Belonged to Chief Justice Ansel's widow.

Q. Did you rent that?

A. Rented it.

Q. And did you—do you have any vacation homes or addresses?

A. No. Can't afford that.

Q. During the two year period that is apparently the subject matter of your suit, you did stay in Florida quite a bit, I think with your wife, didn't you?

A. Not in Florida.

Q. Some of the claims came from St. Petersburg, Florida.

A. St. Pete. Are you sure you are not talking about New York City?

Q. Believe me, I am not——

A. I don't know because——

Q. Don't presume that I know any facts about it.

A. She had twenty-four years of her medical problems, a lot of surgery. Most of which occurred in New York City. St. Petersburg, [26] Florida, I shoot a blank on that.

Q. When is your re-election date?

A. January the 17th or 18th or 19th, one of those three days, it falls after the first Monday after the second Tuesday or what ever it is, 1981.

Q. It's a six year term?

A. Yeah.

Q. Is it your present intention to run for re-election?

A. I don't think that is any of your business.

Q. Do you have a present intention?

A. I don't know whether I do or not.

Q. I gather from that that you don't think that being a Supreme Court justice has anything to do with this litigation?

A. No.

Q. You have made no public announcements about your intent?

A. No. I don't give much concern with those kinds of things.

Q. At the time you became a judge in [27] 1974 did you have any health or hospital or disability insurance policy?

A. Oh, yes.

Q. Do you know who they were with?

A. Well, we went, you know, because of the wife's chronic illness over the years and my own surgery and illnesses before my heart attack, the office had had group policies with Aetna, with St. Paul, Mercury, with New York Life, there is a reference to some of those in this old file. I stripped this file, but there is correspondence with different companies. And Blue Cross also. Those are the only ones I can remember.

Q. Okay. Did you have a Blue Cross policy when you went on the bench?

A. Yeah.

MR. RUTLEDGE: Are you talking about——

A. I had a contract, yeah, so-called private contract.

Q. Do you remember what type of contract that was?

[28] A. I can remember it's type A, seems to me, whatever the hell that is.

Q. Do you remember what the amount of the deductible was?

A. Fifty dollars. No, twenty-five way back then. See,

my mother—subscribe to Blue Cross in 1935 you got to get five families and she rounded up us and four others.

Q. Then as far as you know were you a Blue Cross insured from the time your mother took out that policy in '35 up until the time you went on the bench in '74?

A. Yeah.

Q. When you went on the bench in that——

A. See, that was in addition to the group policy at the office.

Q. All right. In other words, let's talk——

A. At the law office.

Q. Let's talk about the year '74. Is it your recollection you had an individual policy?

A. That is right, with dependent's coverage in '74 would have been only the wife.

[29] Q. You also had group coverage with your law firm?

A. With one of those various companies that kept—they didn't like to write them because of my illnesses and my wife's kicked the rates up on the others and they would swap and get another company.

Q. All right. So you don't remember who that insurer was?

A. I named those from time to time.

Q. Could you give me those names?

A. Let me see if I can find a reference to them in here. Okay. This is—let me see now, this is '73. Guardian. That was who the policy was with at that time.

Q. Would you give us that full name?

A. The Guardian Life Insurance Company of America, Incorporated, State of New York it says on the form. And

let's see if I can go back, go up in time, if that is what you want.

Q. Give me the dates, if you can ascertain them.

A. This claim that I'm looking at was [30] filed on January the 22nd of '73 for epidural, block, hospital for special surgery in New York and there was a claim filed on 9-21-72 for anterior spinal fusion L4 and 5 for my wife that had taken place on 8-30-72 and the, this was some follow-up something or other. I think an attempt to get some relief from the continued pain because the fusion didn't really work well. None of them did, seven of them.

Q. Seven, your wife had seven fusion operations?

A. Yes. Well, she had ten procedures but seven of them were for fusions.

Q. How many—have you had a back fusion?

A. No, I had a fatty tumor in my small intestine in 1963 in March. That was removed and then I had an interstitial hernia from coughing, had to go back in July and have that repaired. Looks like Guardian—no, the last one we had was New York Life, I believe. Here is June 13th, '71 she was admitted, special surgery. She had a hematoma in her right leg, [31] phlebitis. And I say her, we say we had an individual Blue Cross, like I thought I recall at the time. Let's see, Guardian, '71.

Q. You have now handed me a card issued June 1, '71 by Blue Cross which refers to a CN6 type contract number 301222, is that correct?

A. It says conversion on contract number all waiting periods served. I suppose, I think they came out and issued a new policy, a new certificate on the previous one. The old computer could tell you that. This is mine, it's Beaumont, Texas, I believe it is. Here is the surgery on me.

Q. What date is that, Judge? It appears to be March 20th, '63?

A. Yeah.

Q. Is that the surgery by Dr. Patton?

A. Yeah, Dr. C. B. Patton.

Q. Is that the only surgery that you have ever had?

A. No, I had an appendectomy when I was thirteen years old.

Q. Have you had any since 1963?

[32] A. I had that interstitial hernia repaired in July, went back in. It ripped loose inside when I was coughing from pollen. I had never been allergic to a damn thing up until that time. These are all records. If they have any significance just tell me.

Q. Well, what my question was that got us on this track was what insurance policies you think you had in '74?

A. Looks like Guardian and Blue Cross.

Q. And New York Life?

A. I don't know why I don't find any reference in this file because I stripped these files of everything except what I thought was significant as a medical record after the wife died, all the correspondence and stuff that deep, indicating six to eight inches, and so that is why I can't pinpoint and I don't have it. These just show things of a diagnostic nature and surgical procedures so that I would have it when I was in some hospital they wanted to know about my history, see.

Q. Did you ever file any type of lawsuit [33] against any of those insurance companies?

A. No, no, I don't think so.

Q. Other than this lawsuit have you ever filed a lawsuit?

A. I have sued some clients for fees, but that is with the firm. Damn if I remember filing a lawsuit. I can't recaall. I may have, but I don't think so.

Q. Did Mrs. Embry ever file a lawsuit, to your knowledge?

A. Yeah. What started her problems was a woman rear ended her up there on North Woodward Road back in 1960, I believe it was, seems like it was November of '60, she had a riding group, little bitty kids taking them to kindergarden, she was going west and this woman coming from the east watching a full grown tree in front of a residence hit her and knocked her twenty-five feet in a Valiant and the kids went around like the lottery balls, not a damn scratch on them. And she didn't think she was hurt except she couldn't get up the next morning, couldn't move her neck. That started her [34] problems. The only successful fusion she had was in the surgical spine.

Q. And a lawsuit was filed as a result of that?

A. Yeah.

Q. Did you file a loss of services claim at that time?

A. I'm sure I must have. Herbert Peterson and Jim Haley represented her.

Q. In the prosecution of that claim?

A. Yeah. Huie, Fernambucq handled the defense.

Q. Can you recall any other lawsuit Mrs. Embry filed?

A. No.

Q. When you went on the bench——

A. Oh, yeah, wait a minute. There was a mink coat missing out of the house and we keep looking—I keep looking for it after she died and made a claim with Maryland Casualty and they ignored it and I filed suit for that. It was a schedule, two thousand dollars and somehow the

agents had never turned it over to the claims [35] department. I don't know what happened, but we settled it. They paid the two thousand and a fee.

Q. Approximately what year would that have been?

A. It had to be in '84. Filed it in the district court up here.

Q. Jefferson County?

A. Yeah.

Q. Who represented you?

A. Lee Reeves. He worked for me when I was practicing law. He is over at Sirote, Permutt. Cliff Reeves' son.

Q. Clifford Reeves was your law associate at one time?

A. In a sort of fashion. He had space in our offices.

Q. Did you sue for bad faith?

A. Yeah, sure as hell did. Got that fee.

Q. And that would have been a suit in your name?

A. Yeah.

Q. Didn't file any type of class action?

[36] A. No, no. They just goofed up like the casualty companies do, and other companies.

Q. In other words, you think they were just negligent?

A. They were. They just, it got in some bin with all these tons of paper that float around all over the place and was ignored, but that got their attention, they were very nice about it.

Q. Is it your understanding in a tort of bad faith that a negligent breach of contract constitutes——

A. I don't know, I would have to look it up.

Q. Have you ever written an opinion in a bad faith claim?

A. I think I have.

Q. Do you recall that case?

A. I have written several of them, but names of cases, the most recent one I can recall is the procurum opinion, Aetna Life Insurance Company versus Levoy. But I had to write a procurement because I cited one of my dissents.

[37] Q. Explain that.

A. I had dissented in an early case in bad faith about a standard of evidence and all that, but I didn't prevail, but it also had some beautiful language in it otherwise, so I have made reference to it in the Levoy opinion.

Q. And for that reason the opinion is procurum rather than——

A. Right. That plus I took it over from another judge. It's customary a lot of times in procurum, if it's been assigned to you because the other opinion didn't prevail, I learned that. None of this stuff is written down, though.

Q. Just custom?

A. Yeah, it's always been done this way, so we do it.

Q. Do you recall, I know we can find the exact date of the issuance of the opinion, but do you recall when you wrote the Levoy procurum opinion?

A. It's on rehearing right now. So the opinion came out right before Christmas or right after Christmas. It was right before Christmas, [38] I guess.

Q. Do you know when the opinion was written?

A. Published?

Q. No, not published, when you wrote it and before it was circulated.

A. I wrote on it for eight or nine months.

Q. And that would have been the first eight or nine months of 1984?

A. Yeah. See, that case is history. It's first submitted on briefs.

MR. RUTLEDGE: He didn't ask you that.

Q. Well, go ahead.

A. That is extraneous stuff.

MR. RUTLEDGE: You are heading toward getting a judicial interpretation in this one. Somebody is going to have to order to give you Judge Embry's interpretation.

A. I don't know what it is.

Q. Do you recall the date that it was submitted to the court, approximately?

A. Not originally.

[39] Q. Would it have been prior to January 1st, 1984?

A. Oh, hell, yeah.

Q. And before your counsel interrupted you you were telling me——

A. It was submitted and argued over and resubmitted.

Q. And have you got any judgment as to that, would it have been as long ago as '82?

A. Well, no, no. Well, I don't remember but it's been a long time.

A. It's been up there four times.

Q. And was your——

A. We are talking about the last admission now.

Q. Was your—when you first started writing on the opinion in that case was it a—you thought it to be a dissenting opinion, did I infer that?

A. Yeah, yeah.

Q. And do you—can you tell me the approximate date of when that became the majority?

[40] A. Oh, yeah. Back in about November, December of this past year.

Q. As I understand what you have said, the case was taken under submission without oral argument originally?

A. Ori ally. The last appeal resubmitted on brief.

Q. And was it on the court's motion that it was set down for argument?

A. Yeah, after discussion it was deemed appropriate to unsubmit it, whatever you call it, set asside submission, order it argued orally so the lower court could hear it and resubmit it after that.

Q. And do you recall when, approximately when that, let's call it the order of resubmission or unsubmission?

A. Back in the spring, as I recall, of '84. Because I know it was argued before the summer recess. We don't have a recess, but before the last of the oral arguments held in June, normally, sometimes it will go to the first week in July.

[41] Q. Had there been drafts of an opinion before the decision?

MR. RUTLEDGE: Justice Embry, let me tell you that I do not think you should be disclosing the——

A. I don't think so. I hadn't thought about it. That is part of our—even though we've had some groups that want to open up the conference room to the press——

(Off-the-record discussion.)

MR. RUTLEDGE: I don't know——

A. That is correct.

MR. RUTLEDGE: I don't know what your objective is, and I'm very, very reluctant to ever instruct a witness not to answer a question, but I have—it's my understanding that the negotiations among the judges, if that is the right terms, are confidential and without some showing I don't intend to allow Judge Embry to discuss how a certain opinion came to be written.

A. So far all I have stated was the mechanical, but that is as far as I will go.

Q. And you have given me your best [42] recollection about the dates?

A. Correct.

Q. And that was the case of Aetna Life Insurance Company V. Levoy, that was the style of the case?

A. Right.

Q. You have mentioned to me that you gathered up these documents and have shown us here, I haven't had a chance to look at all of them, did you do anything else in preparation for this deposition?

A. No.

Q. Didn't review any other written material other than what is here?

A. No. I read some stuff at his request.

Q. What did you read?

A. His memorandum.

Q. Legal memorandum in this case?

A. Yes. He wanted me to have an idea of what the case was about.

Q. Now, when you went on the bench in January of '75 did you cancel any insurance coverage?

[43] A. No, it was a roll over, I would call it, I would say came under the group deal rather than the individual Blue Cross contract and, of course, I was no longer covered by Guardian or New York Life, whoever had the office group, no, not health insurance, if that is what you are talking about.

Q. How about disability insurance?

A. I have disability, income disability policy with Paul Revere.

Q. Do you recall approximately how long you have had that?

A. Oh, goodness, well, I had it for several years while I was practicing law because it's the type thing you draw so much money a month in the event you can't perform the usual duties of the occupation or in the case on me being on the bench, the normal duties of your office.

Q. Have you ever made a claim or received any benefits from that policy?

A. No.

Q. Did your wife ever receive any [44] benefits from a disability policy?

A. Didn't have any, she didn't have any policies for disability.

Q. We've talked about a group policy that you had through your office as being a Guardian or New York Life policy, did you attempt to roll that over or renew that when you went on the bench?

A. No. If you are not in that group, as I understood it, you can't qualify. I suppose you could have gotten a private contract with them, I suppose, I don't know.

Q. Now, when you went on the bench in '75 do you know

who, what insurance company, if any, administered the state plan?

A. I don't know. Mr. Thrasher testified about all that. I don't really know. I know when I went on the court the card didn't have anything on it except Blue Cross.

Q. Did that subsequently change?

A. I'm sure it did because the card I have now shows this, whatever it's now called, something about state employees health insurance [45] plan or something like that. I don't seem to have it.

Q. Do you know whether the state plan has been administered by Blue Cross the whole time you have been on the bench?

A. I don't really know that. I would be just supposing and whatever, so I better not get into that.

Q. Your income tax returns indicate that you have made claims on health insurance carriers from the year '78 forward.

A. Well, long before that, but I didn't have those returns. I couldn't find 1980's.

Q. But would it be your recollection that for every year since 1975 that you or your wife had made a claim or had benefits paid on your behalf by a health insurance carrier?

A. Oh, hell, yeah.

Q. Did you, as I understand your lawsuit, you're seeking recovery for damages suffered for——

A. I think the lawsuit speaks for itself.

Q. Right. From October 1st, 1982 [46] forward, is that correct, till the time——

A. If that is what is alleged.

Q. Did you ever have any difficulty with processing claims prior to the date?

A. Jesus Christ, that is a silly question. For years and years. When your daddy was representing them he suggested I sue them back in 1978, '77, somewhere along in there.

Q. And that is when you were on the bench?

A. No, '60, what am I talking about. Because old Miller, I went over there to see him.

Q. You went to see Mr. Miller in '68?

A. Yeah, because they presented me with a bill in New York for seven thousand dollars, said my amount of days had expired, which hadn't. I told them to hold it and I called your father about it. He said I can't make them do anything. Miller was the executive vice-president, as I recall it, and I went over there and talked to him about it. He said blame it on computer, as usual, said he would write the New York Interplan Bank. I said no, you call them right [47] now, so he called and got it straightened out.

Q. Were you paid the full amount of the hospital charges or a portion?

A. Well, they paid the hospital charges on the regular, see, I didn't have any major medical, I had Guardian on that. This was just a straight hospitalization policy. It wasn't Blue Shield. That was for one week in the hospital.

Q. And this, you mentioned the Interplan?

A. Bank.

Q. Bank?

A. That is what he called it.

Q. What is your understanding of that?

A. It's some sort of exchange, like if you get sick in New York, as I understand it, Alabama Blue Cross covers you and they make payment through this Interplan bank or fund or whatever the hell it is in turn New York City Blue Cross, as I understand it pays the hospital.

Q. And did you threaten to sue Mr. Miller or Blue Cross at that time?

A. No, I just let him have a piece of my [48] mind.

Q. What did you say to him?

A. I told him it was a hell of a note to get up there and wife lying there helpless and be presented with a bill when you knew you had the coverage and this was just a ploy to stall and hold on to the money, which it was.

Q. That is what you told Mr. Miller in 1968?

A. Yes, sir.

Q. And it was your understanding at that time or your belief at that time that that was a device by Blue Cross to hold on to the money?

A. Looking back on it.

Q. Well, did you tell Mr. Miller that?

A. I said you are stalling to hold on to this damn money because you see I had gone up there and she had been diagnosed and the fellow wanted to do the surgery in 1967, these dates could be a year or two off, and I said no, we run out of, she had been in the hospital here, I said our seventy days will be up in four our five days. I said you schedule for the [49] following year in the new seventy days, so he did and we went back the following year, after the calendar year had started running where we had the full seventy days, because I couldn't afford to pay it out of my pocket at those prices, even in those days.

Q. And this was on your wife's surgery?

A. Yes. The next surgery.

Q. And as I understand it——

A. No, this may have been one of the back surgeries.

Q. But her eligible hospital days had been expended for one calendar year?

A. Short five days. So we began the new calendar year and scheduled the surgery for the following year.

Q. You rescheduled it?

A. I think one of these things show January the 21st or 20th, something like that.

Q. And——

A. So that would have been the back.

Q. And did you express to Mr. Miller or any other representative of Blue Cross in '68 [50] that it was your belief that——

A. I just said it looks to me it's just an effort to delay payment. I didn't really get angry about it, I was upset because, my God, all the money I had spent over the years on hospitals and doctors and all, the whole family, and I wasn't in a position to pay that bill at that time. I would have had to borrow the money.

Q. Can you recall anything else you said to Mr. Miller?

A. That is about the substance of it. I don't remember the exact words. We had a very pleasant visit.

Q. You mentioned you discussed that with my father.

A. Yeah. I called him.

Q. Did you have any other discussion with him that you haven't told us about that claim?

A. No, I had called him because I informed——he was the general counsel, and he and I were friends and I asked

him what could I do about it and he said we had a conflict, he [51] suggested I go over and see this fellow.

Q. As far as you recall Mr. Miller is the only person you talked to?

A. Yeah, in his office. It was over there on 20th Street at that time.

Q. Now, did you have any other difficulty with any type of hospital or medical insurance or health insurance claim?

A. Not with other companies, no.

Q. Never had one with any other company?

A. No.

Q. Had no——

A. They were helpful and prompt, they would help you process a claim, as a matter of fact.

Q. Under the state plan, after you became a judge under the state plan can you recall the first time that you had any difficulty?

A. Every time you file a claim it was all forever processing, but also this business of need more complete information, this, that and the other when all the damn information had [52] been furnished, but also little things like inadvertently put my Social Security number on a claim instead of four eighteen I just put three eighteen. Well, hell, y'all probably got four or five disks of computer records over there of me and I got that thing back says can't process the claim without more complete information.

Q. Do you recall when that occurred?

A. It was one of those claims arising out of my wife's—after she was dead, but see, the radiation, as I recall it, they threatened to sue me, the radiological people because Blue Cross hadn't paid them, so finally I sent them a form and asked them to fill out and send it to me. That may or

may not have been the one that was kicked back, but they dribbled that stuff in me in forty or fifty dollar lots and there was three thousand and some odd dollars. I would get a check for one hundred fifty or two hundred dollars every two or three weeks. Went on forever. That is when I started getting angry about it.

Q. And that would have been sometime [53] after your wife's death?

A. Yes. It's been last year, early part of last year.

Q. Well, suit was filed?

A. I'm trying, you know, the last radiation she had was in early September or late August and that last chemotherapy treatment, which was a precautionary follow-up thing is what killed her, but it was claims arising before that because claims of the losses incurred as a result of her last two or three days last illness. They were paid rather promptly comparatively.

Q. Those were claims that you said were paid rather promptly would have been in——

A. For that intensive care isolation deal.

Q. Treatment rendered in '82?

A. No, treatment rendered immediately prior to September 20th.

Q. I see, immediately prior to her death?

A. Yeah.

Q. So, as I understand it, some of the [54] claims from the fall of '83 were paid promptly and others were not?

A. No, the ones that had been incurring, see, she went for radiation three or four days a week for, oh, God, I don't know how many months and those things were, the radiological group were filing those things all along, at least I was assured they were. I had no buzz out of them

until all of a sudden I got past due and all that mess, several thousand dollars and then I don't know whether I talked to anybody at Blue Cross or what, but then when I got the thing, kept saying past due and, of course, that is when I said, well, look, let me send you a form and you fill out one of these major medical claim forms, put all the stuff on it and I'll file it, and as I recall that was what was done.

Q. All right. In this particular claim was for the——

A. Radiation therapy.

Q. Administered by, you said the radiologist?

A. Dr. Dick over in the—what do they [55] call that thing, there is a unit over there in Baptist Montclair that they don't—it's not the regular x-ray outfit, it's therapeutic x-ray.

Q. Is it in the doctor's office building?

A. No, it's in the hospital, but this Dr. Dick is the head of it.

Q. Nuclear?

A. Yeah, nuclear because they have cobalt.

Q. Is Dick D-i-c-k?

A. Yeah, he was a little bitty fellow, balded.

Q. Now, you have mentioned radiology group. Is it your understanding——

A. That is the unit in the hospital. The radiology group that serves the hospital, of course, they have lab facilities in the hospital, that is a different deal. That is for, you know, upper GI series or whatever.

Q. I'm going to come back to this, but before we get off of it, the specific claim that you say that you got a past due notice on, was that from Baptist Montclai. Hospital?

[56] A. From the nuclear medicine or whatever it is in the hospital.

Q. Was it your understanding that it was from the hospital itself or was it from a group of doctors?

A. I don't know what the setup over there is. Usually the bill shows on it something like Baptist Montclair nuclear radiology group or something like that, but it's not just the people that take x-rays. These are therapeutic. They bill you separately. The hospital doesn't bill you for that.

Q. Do you have a copy of one of the bills so I can get that name?

A. Is that that stuff that Gene had?

Q. Yes.

A. Let me look in that and see. Probably one of those claims.

(Recess.)

Q. Did you—while we took that break did you find the name of that group?

A. It's right there on top.

Q. All right. Show it to me, if you [57] would.

A. Okay. Baptist Medical Center outpatient therapeutic, that just describes the service, I suppose. I think it's the next page. Birmingham Radiological Group, P. A.

Q. And that is the group?

A. Professional Association, I take it because it shows outpatient x-ray therapeutic.

Q. And is that the group that sent you the past due notice, as far as you can recall?

A. Yeah.

Q. Is Dr. Dick that you mentioned a member of that group?

A. No, he is a member—it may be that the same group operates the regular x-ray, if that is the name of that group, but this is a separate unit and Dick is the head of it.

Q. What is his first name?

A. I don't know.

Q. Now, if I can go back——

A. John or Jonas.

Q. You told me about the difficulty you had in 1968 involving——

[58] A. Or thereabouts.

Q. Involving the New York plan. Incidentally, you said my father told you to sue. He didn't tell you to file a claims suit, did he?

A. We didn't discuss it, but in Alabama at that time we didn't have any of these damn fool rules.

Q. That you are now utilizing?

A. Yeah.

Q. It's apparent you don't have to do that any more, do you?

A. No, write a letter.

Q. Now, Judge, between that incident and the time you went on the bench in January of '75 do you recall any other difficulty you had in any claims processing with Blue Cross or any other?

A. Just slow, slow pay, slow reimbursement.

Q. Did you have any difficulty with Guardian or New York Life that you recall?

A. No.

Q. Do you recall having any [59] correspondence with either of those companies concerning claims?

A. I don't think so, because they had local agents, I remember, well, Wilmar Point, he was the head of Guardian and they would come to your office and help you with it or tell your secretary how to do it.

Q. And this was junior or the third or fourth?

A. Third.

Q. He is the one who is now deceased?

A. No, young fellow whose picture you always see in the New York Life adds, billion dollar round table, whatever they call it. A fine young fellow.

Q. By young you mean his early forties?

A. Younger than I am.

MR. RUTLEDGE: My age.

Q. Judge, prior, we've discussed, then, the only, the difficulties you had prior to January of '75. Can you tell me about the specifics of any difficulties that you had with health insurance claims between January of '75 [60] and September 30th, 1982 and with whom?

A. Blue Cross.

Q. All right. With any health insurance?

A. Well, that is the only one I had except the American Family, American Family paid very prompt.

Q. Well, let me ask you this, you remember the dates I gave you were till September 1982?

A. Yeah.

Q. Did you have a claim with American Family prior to that?

A. No, I thought you were talking about the last year.

Q. Concentrating, if you will, in January of '75 and September of '82, do you have any recollection of having any difficulty of any health insurance claims processed in that period of time?

A. Through Blue Cross.

Q. Can you recall when that——

A. Well, see——

MR. RUTLEDGE: Let him finish the [61] question.

A. All right.

Q. The specifics of any of those, specifically the dates?

A. No, I don't remember the dates. It was just a running deal because I have these chronic ailments, so does Bedford, my wife, and go to the doctors, and on a couple of occasions had to be hospitalized. See, I have got a hiatal hernia and esophageal spasma sometimes and it's the same old story forever and two days and on occasions there will be this business of incomplete information over what is the diagnosis, and, of course, it's all on record. Hell, I can list what is on the old records, hypertension, angina, hiatal hernia, hormone deficiency and some other damn fool ailment. Gout and a few others. Just old age.

Q. Is it your judgment, then, that there were difficulties in every year from 1975 up until September of '82?

A. Yes, sir. They are the same nature.

Q. Of the same nature?

[62] A. Yeah.

Q. And the same, by the same nature you mean slow pay?

A. Delayed payment or reimbursement on occasions, silly kickbacks for the information that is already in your files, but I would dutifully send back the information.

Q. During the time between January '75 and September

'82 were the difficulties that you had any more pronounced in any particular year or do you have any recollection of that?

A. The things most vivid in my mind is claims arising from her cancer, my wife's cancer.

Q. You told me now that was diagnosed after?

A. I don't remember the date.

MR. RUTLEDGE: He is asking you right now about through September, '82.

A. Oh, '82, same that I have chronicled.

Q. During that period of time did your wife continue to receive treatment in New York?

A. No, I think the last time we were in New York was '79 or '80, I don't——

[63] Q. Mr. Rutledge is becoming impatient with me, but I want you to concentrate between——

A. I'm concentrating.

Q. Listen to me. Time frame.

A. I'm bad not to listen.

Q. Lawyers are worse, aren't they? January of '75 when you went on the bench through September of '82.

A. All right.

Q. Now, during that period of time did Mrs. Embry receive treatment in New York?

A. No.

Q. Did you?

A. No.

Q. Do you recall any out-of-state medical treatment during that period of time?

A. September '82, '75, yeah, Beaumont, Texas, I'm thinking of myself now, but Bedford, no, I don't think we took her to New York after I went on the bench, I couldn't afford it on salary.

Q. An expenditure of several thousand dollars would be a major expense to you, is that [64] what you are saying?

A. Well, I don't know, I have spent over three quarters of a million dollars since she first got hit in 1960 on her illnesses.

Q. So——

A. And expenses incident to it that are not reimbursed by insurance, hotels, air transportation.

Q. So an expense of two thousand dollars would be a major expense to you as a salaried person, would it not?

A. At any one moment writing a check for to two thousand dollars, I could go in savings.

Q. Can you tell me again, getting back to this time frame, '75——

A. '75, '82.

Q. Was the difficulty in processing claims any more pronounced or can you remember any specific incidents of difficulty.

A. Delay in payment and the kickback on need further information crap.

Q. Would it be your testimony that that difficulty was level throughout that period of [65] time?

A. Chronic, all the time.

Q. You noticed no dramatic improvement or worsening of the service during that period of time?

A. Seemed to get worse. That is the impression I have

because it got longer and longer and it's been pretty bad since I filed this lawsuit.

Q. Is whatever information that you have concerning those prior claims, whatever document that you have in these two files that you have?

A. All I have. Of course, their computer has it all.

Q. I'm particularly interested in claims with other insurance companies.

A. I don't have any. You are talking about that time frame, American Family——

MR. RUTLEDGE: Well, he is asking you about September, '82.

Q. Is it your understanding or your recollection——

A. Okay.

[66] Q. —that during that time frame, '75 to '82 that the only health coverage you had was through the state employees' plan?

A. Except for the cancer policy.

Q. Except for the cancer policy?

A. Right.

Q. Did you read any description of your plan before this deposition?

A. No, not recently.

Q. You have given me a blue book?

A. Well, that is not the current one, I don't think.

Q. You say it has an effective date. What is it?

A. 10/1/82. This is the same content, well, there was one change that isn't mentioned in here, no, it is mentioned in here. This occurred after 1980, this claim filling limita-

tion, three hundred sixty-five days, that is the only change I noted in the phamplet. Of course, I took a glance at the policy.

Q. When did you do that?

A. It's been several years ago. You [67] have a claim service officer on South 20th Street and I used to take these claims there rather than mail them. There is a nice young lady up there that is very efficient and all and she sent them out and whatever. And I had not known of that thing and she explained it to me, I said well, that is the first I had ever heard because at that time it wasn't in the then current pamphlet, so she went back in the back there and got a big old thing about that long and about that thick which was the master policy, or the policy.

Q. The policy——

A. And she showed that provision that had been put in at some point.

Q. You referred to the policy. Are you referring to some type of contract with the state insurance.

A. No, it's a contract between Blue Cross and the state employees. It's group number thirteen thousand.

Q. All right. Now, the provision to which you directed my attention is lawyers [68] health insurance plan booklet appears on page seven and refers to a limitation that claims for benefits must be submitted no later than three hundred sixty-five days following the date covered expenses are incurred?

A. The loss, yeah.

Q. And do you recall approximately when you had this discussion with the young lady?

A. I have no idea.

Q. It would have been sometime prior to October 1st, 1980?

A. Is it '80 or '82. Look here, the card.

Q. I'm looking at the card, but I'm looking here at the date of the health insurance plan.

A. I had not seen it in the previous phamplet. As a matter of fact, it wasn't in the previous phamplet because I know someone who filed a claim and picked up back expenses that was four or five years old.

Q. Who is that?

A. Judge Almond. His wife died of [69] cancer after a long, long, long illness and his secretary made belated claim and collected.

Q. Do you recall, I think she died in '79?

A. I don't remember, because I never knew his first wife. He was on the court of criminal appeals at the time so it had to be before '79 because he came on our court in '75, the same day I did.

Q. So it would have been sometime before '75?

A. Yeah.

Q. And the provision to which you directed my attention——

A. Claim limitation.

Q. And it does appear in the employees health insurance plan booklet which was distributed to you by the state and had an effective date of October 1980 on it?

A. I didn't get it at that time. I had to request it much later.

Q. From whom did you request it?

A. I'll tell you when I requested it was [70] the date of that card.

Q. Now, you have shown me a card?

A. I put scotch tape on it.

Q. Scotch taped to the book that shows your contract number and an effective date of October 1st, 1982, is that correct?

A. The occasion for the request was when I talked to the young lady on South 20th Street and she showed me the provision in the group policy. When I got back to Montgomery I requested an up to date phamplet.

Q. Did you have——

A. Certificate or whatever you call it.

Q. Did you have claims denied on the basis of that limitation?

A. I don't recall. I know I have had the new deduct imposed each year, an additional two hundred dollars when she was living.

Q. Other than that, looking at the planning at that time, which apparently would have been in October of '82 or thereabouts?

A. I don't remember. Time fleets by.

Q. Have you read the, either the policy [71] contract with the state——

A. No, the only thing I have consulted since that time that I saw it up there was this thing here, this phamplet.

Q. This phamplet. Who did you receive that phamplet from?

A. I don't know, I just asked my secretary in Montgomery to get me one and I think the Clerk's office distributes those, I am not sure.

Q. The clerk of the Supreme Court?

A. Yeah.

Q. What is your secretary's name?

A. Mrs. Mildred Gandy.

Q. And has she been with you the entire time you were on the bench?

A. Yes. She was with Judge McDaul and I kept her.

Q. How did you receive notice about the cost of the dependants coverage under the state plan?

A. They distribute these, hell, paper, when I do go to Montgomery there is a stack of [72] damn paper on my desk that has been distributed in the previous week and we always get these memos and it's always something to do with effective such and such a date, dependent coverage to be increased or whatever. It's just a paper world.

Q. And then that would be deducted from your check, is that right?

A. Not now, no.

Q. You pay that independently?

A. No, I don't have any dependents.

Q. I understand that, but when you did have dependent coverage?

A. Came out of payroll deduction.

Q. And you personally have not, since you have been on the bench have not made any payments for your personal coverage, is that correct?

A. No, I wouldn't have any personal coverage, if you mean a private contract aside from the group.

Q. It is a fringe benefit to you as your employment as a judge, is that correct?

[73] A. I imagine what you would call it is a part of your compensation, I suppose.

Q. Is that, do you know, is there any question as to whether or not that——

A. As far as IRS is concerned, no, I don't know.

Q. All right. And do you know——

A. Other than what Thrasher said.

Q. Do you know whether or not there has ever been any consideration as to the, whether any variations in that coverage constituted an increase or decrease in your remuneration for any purpose?

A. I don't really understand the question.

Q. Well, you know, you are aware that an elected official can't have an increase in salary under the Constitution of Alabama?

A. No, that is not true, judicial. You are thinking about the Boutwell Amendment, you know, the judicial article, we are not bound by that.

Q. Tell me how your compensation——

[74] A. If we are lucky enough to get a raise, which is unlikely, we get it during our term.

Q. How is your compensation fixed?

A. By statute.

Q. You told me that it can be varied?

A. Per annum.

Q. Per annum?

A. No, they varied it by Fiat, cut me out of seventeen hundred dollars that I'll never recover because the computer screwed up.

Q. Talking about Judge Haley's decision?

A. Yeah, his damn fool decision, he took care of trial judges, screwed us.

Q. All right. But otherwise how is judicial compensation set?

A. By statute, so much per annum.

Q. Are you telling me that that cannot be varied other than by a subsequent legislative act or is there a board, compensation board?

A. Well, we've got an increase by luck as state employees proviso to exempt us from the increase was taken out so we got the ten percent that the other state employees got effective, I [75] don't know——

MR. RUTLEDGE: I don't mean to interrupt, but if the statute says he can or says he can't, whatever he says wouldn't add anything to it.

A. I'll have you to refer to the statute.

MR. SIMPSON: Gene, he's not claiming any damages from loss of compensation in this suit, is he?

MR. RUTLEDGE: Well, I don't know whether he is or isn't, but the point I'm trying to make with you is his view as to how the judicial is compensated or isn't, unless it's in an opinion he writes it doesn't mean anything.

MR. SIMPSON: Unfortunately I haven't got anybody else I can ask these questions of.

MR. RUTLEDGE: You have the statute and the cases. That is a matter of law, not fact. I'm not trying to be argumentative. We could be here for a month.

Q. I'm trying to limit the——

A. Suits me, this is better than working.

Q. I'm trying to limit the issues if we [76] can get the parties to agree on them. You are not claiming that your compensation has been altered as a result of any action on the part of Blue Cross or the State Employees Insurance Board?

A. I'll have to refer to the complaints. I gave all these facts that I knew to Mr. Rutledge and he represents me. His theory of law and all is what I'm traveling under. I don't have any independent thoughts about it.

Q. Do you know of any evidence of any kind that would bear on the issue of whether or not your salary or compensation has been effected in any manner by the actions defended in this case?

A. That would depend on an analysis of the entire scheme of the package of compensation consisting of stated salary plus these, what you refer to as fringe benefits and the effect of the defendant's actions on the cost of that to me and to other state employees.

Q. All right.

A. That is the best way I know to answer [77] it.

Q. Do you know of any evidence that the actions of this defendant have effected?

A. It would be in your company file.

Q. I'm asking what you have knowledge of.

A. I don't have any knowledge of it because I made an analysis of it.

Q. So you have no such evidence?

A. I would have to have all of y'all's records.

MR. RUTLEDGE: There is a follow-up of the question—that is all right.

Q. Is the answer to the question no, you do not have any evidence one way or another?

A. If you are talking about sitting here in my possession, in my knowledge without digging into all these records and all of yours and the state's, no.

MR. RUTLEDGE: And excluding from your answer anything I have done in preparing for this case?

A. That is work product of us, that is not my deal, I just give you the facts and you [78] work it out.

Q. That is all I want is the facts. You don't know of any facts?

A. I have got a lawyer to represent me. I don't represent myself, that is crazy.

Q. You are in Montgomery a fair amount of time and you are down there and under the workings of how state employees salaries are effected and do you have any facts?

A. I don't know how the system works.

Q. You have never had anybody telling you that your salary has been highered or lowered as a result of any action on the part of any defendant in this case?

A. No one has told me anything. What I have been able to find out I have to dig for it.

Q. You have never seen anything in writing that increased that conclusion, your salary had been effected one way or another by the action of this defendant?

A. I think what you are asking me calls for a legal conclusion and I ain't going to make a legal conclusion because I am not the judge or [79] jury.

Q. Have you seen anything in writing and discussed in any manner——

A. To the effect or conclusion——

MR. RUTLEDGE: Let him finish the question. Go ahead.

Q. —discussed in any manner the administration of the state employees health insurance plan or the, any actions or costs of Blue Cross/Blue Shield of Alabama on——

A. No.

MR. RUTLEDGE: Wait a minute, Judge.

Q. —on the level of compensation which you have received?

MR. RUTLEDGE: Are you excluding from your question, Mr. Simpson, work that I have done in preparing this case for trial, which I may have shown my client or are you including that?

MR. SIMPSON: I'm including that.

MR. RUTLEDGE: Well, we refuse to answer the question because that would call for disclosure of my work product in your [80] questioning the witness. If you will exclude that I'll have no objection to it.

MR. SIMPSON: Well, Gene, I don't want to exclude any document which you have shown him. I'll include that any do ument prepared by your counsel.

MR. RUTLEDGE: Well, if you will exclude from your question anything that I have prepared or had prepared by persons I have retained for that purpose to be used in the trial of this case, then we'll answer the question. If you include that I'll instruct the witness not to answer.

Q. I'll exclude anything that has been prepared by Mr. Rutledge or which he has prepared. You remember, Judge, my question pertained to documents.

MR. RUTLEDGE: Do you understand, Judge?

A. I think so. No.

MR. SIMPSON: I think at this time we probably ought to break for lunch.

MR. RUTLEDGE: That is good.

[81] (Lunch recess.)

Q. Judge, during the lunch break we have had an opportunity to look at these two files which you produced. Do these constitute all the documents?

A. All I got left.

Q. All right. And by all the documents I mean any correspondence or records of medical records or claim forms or anything relating to the medical claims involved in this lawsuit?

A. For that period of time.

MR. RUTLEDGE: That he has?

A. That I have.

Q. Do you have any others that are available to you from any other source?

A. Unless he has some more in his file and like the 1980, or '81 tax return, I don't know where it is.

MR. RUTLEDGE: Let me state, as far as I know this is all we have in our possession, but I am not representing that the letters haven't been written or claims haven't been made that are in there because that would be in your [82] records probably better than ours.

Q. All I want to know——

A. There are more documents but those are all I can find at this time.

Q. If we are going to see any more——

A. If I'm instructed to rummage through all my papers at home and stuff——

MR. RUTLEDGE: If we find any more documents we'll give them to you in plenty of time.

A. Right.

Q. Have you made a search for what you think to be relative documents?

A. This morning I was running late and I have been cleaning out my house ever since Bedford died and, my

God, I have never seen as many papers in my life and I found these in different places.

Q. There do seem to be a fair amount of documents relating from September, '82 forward and do you know of any other place where any other might be?

A. I have some subsequent to, well, it [83] covered last year at the office over at UAB. They are copies of claims for medication and doctors services for me.

Q. I think those are called for by the subpoena.

MR. RUTLEDGE. Henry, I'll do the best I can.

A. I can't get my staff attorney on the phone.

MR. RUTLEDGE: If you will let me answer, I'll do the best that I can. This is what part of this has been brought to me over a period of time, this being the fat folder. This was brought in this morning. I do not know of any other documents that we have at this time. That's all I know to tell you.

MR. SIMPSON: Well——

MR. RUTLEDGE: But I am not saying that somewhere in the Judge's house or in his office or someplace on earth he may not have other copies. What I am saying to you is that you have got them at your place.

MR. SIMPSON: Well, Gene, our request [84] isn't related to solely communication with Blue Cross. It includes that, but could be others. As I understand it, the judge has said that he does——

MR. RUTLEDGE: What representation can I make to you that will be satisfactory? Judge, will you search?

A. Yeah.

MR. SIMPSON: What the judge said, he does have other documents for last year, that is '84.

MR. RUTLEDGE: Do you want those?

MR. SIMPSON: Well, I take it that it's the judge's position that it wouldn't be relevant since it came after the suit was filed if you are not seeking damages for anything after the suit was filed.

MR. RUTLEDGE: Get the documents, we'll have them to you in the morning, or do you want them right now?

A. I looked at that subpoena notice.

MR. RUTLEDGE: Well, all I want to do is get on here.

[85] A. Sure.

MR. RUTLEDGE: Do you need them right here?

MR. SIMPSON: I wanted them as soon as you can get them.

MR. RUTLEDGE: I'll have them in the morning.

Q. Now, Judge, I have asked you about the medical records.

A. Do you have any documents of any kind relating to correspondence between yourself or your counsel and any other members of your class?

A. No.

Q. None at all?

MR. RUTLEDGE: Never been none from counsel.

Q. All right. I don't intend for you or your counsel to be bound by any characterization I made about the averments of the complaint, but for purposes of attempting to shorten this I'm going to ask you some questions. I understand that you did not necessarily concur in my characterization, portions of the complaint [86] section damages for claims which you made which were unpaid between September and, or after September, '82. Do you—can you list or denominate those particular claims which you claim are unpaid?

A. No. They would be reflected by some unpaid, small ones, usually, but more particularly by less than full payment

Q. All right. And that is——

A. Full reimbursement.

Q. Let me narrow it now to claims that were submitted and no portion of the claim was paid. Are there any such claims?

A. Yes. I can't detail them.

Q. You can not give me the details?

A. No.

Q. And then there is another section of claims in which less than the full amount was paid and it is your contention that the full amount was due to be paid?

A. Well, the full amount under the terms of the contract.

Q. All right. And are there—do I [87] understand that your complaint states other claims that were paid but were tardily paid?

A. As I recall

Q. All right. Are you seeking personal damages from any such claims that were paid——

A. Personal and for those members of the class that are similarly situated that had claims that were not paid or delayed pay.

Q. You are making a claim for damages personally?

A. My claim is in there with everybody else, I guess.

Q. What I want to know, Judge, I'm trying to determine what type of claim you had. Are you making a claim that a claim was properly submitted and you suffered damages as a result of it not being paid on a timely basis?

A. Right.

Q. Now, insofar as the contract count of your complaint is concerned, and I'll——

A. Do you see the contract?

MR. RUTLEDGE: Let me get a copy of it.

[88] Q. Judge, have you read a copy of the complaint in this case?

A. I saw it before it was filed. As a matter of fact, the same day.

Q. Have you read it since?

A. No.

Q. Are you generally conversant with what it claims?

A. I would have to look at it to refresh myself.

Q. Please feel free to do so.

A. If you would prefer some particular part of it.

Q. All right. Count one of the complaint has, in paragraph two has four subparts.

MR. RUTLEDGE: You mean paragraph ten.

Q. Paragraph ten. Judge, do you see subparagraph A, B and C of paragraph ten there?

A. I did.

Q. And those, in determining what damages that you have suffered under each of those three categories, I take it we will have [89] to examine the particular claims, is that, do you know of any other way to do it?

A. No.

Q. Now, ——

MR. RUTLEDGE: Let me state for the record, how I prove this case won't be governed by Judge Embry's views of it,

it will be how I decide to do it. I'm of the opinion we are about to enter an area of complaint interpretation that in my judgment a client is not in a position to do. I don't want to instruct the witness not to answer, but I do want the record to be clear that we'll not be bound as to meet orders of proof by the answer just given by Judge Embry or any other answer, but if you want to examine him about what the complaint says go ahead, over my objection.

Q. Judge, as far as any documents that you have that relate to your personal claims fall within categories A, B and C of paragraph ten of count one, they are here in these two folders and what you might bring us in the morning?

[90] A. Right.

Q. Do you have any documents or have you seen any documents which in any way relate to subparagraph D of paragraph ten of count one of the complaint?

MR. RUTLEDGE: Do you include or exclude from that question, any documents which I have prepared through this litigation or have had others prepare at my request for preparation at trial?

MR. SIMPSON: I would exclude any that you or your designees have prepared for use in this litigation. I do not exclude any that they might have consulted, any preexisting documents.

MR. RUTLEDGE: You can answer with that clarification.

A. No.

Q. Do you have a judgment—let me withdraw that.

A. I don't have any judgment.

Q. Are you the executor of your wife's estate?

[91] A. Yeah.

Q. Is that still pending or is that closed?

A. Yeah, I'm executor, yeah.

Q. And——

A. No, it hasn't been completed.

Q. That is pending in the Jefferson County Probate Court?

A. Yes.

Q. Are you attempting in this suit to assert any claim for damages which would be recoverable by your wife's estate?

MR. RUTLEDGE: We object to that question because that would require a legal interpretation of facts applicable to them and that is not Judge Embry's function in this case.

Q. All right. Now, Judge, I'll ask the same question, but I'll exclude as a class representative, I'll simply ask you if you are seeking recovery of damages for payment of your wife's estate?

A. I can't answer because I don't know what Mr. Rutledge's theory of the case and how [92] he attempted to prove it.

Q. Are there any medical claims pending against your wife's estate?

A. Against it?

Q. Yes, have any claims been filed in the probate court?

A. No.

Q. All right.

A. Not of any kind.

Q. Have, since the wills were granted have you as an executor in your capacity as executor paid any claims?

A. Medical or hospital claims on behalf of the estate?

MR. RUTLEDGE: As executor of the estate?

A. As executor I have only paid for the funeral expenses

and headstone, things associated with her death, but not medical, but I don't recall at the moment whether I reimbursed myself for having paid for them. The undertaker, and you know how slow lawyers move on these things, so I think it went on and paid [93] it.

Q. Is the estate represented by counsel?

A. Yeah.

Q. Who is that?

A. Danny Markstein and there is a young man in his office that is working with him, Jim Vann, James Vann.

Q. Are there other legatees or beneficiaries of that estate other than yourself?

A. Not now, not at the present. My children were—well, it was a trust and my children have, I don't know what you call it, but they have relinquished their interest to me, so that the truth did not have to be, come into being.

Q. Were you trustee of that?

A. No, Bernard Stein was trustee.

Q. Judge Embry has produced two manila folders, I'm going to put with the Judge's permission, number one and number two on the folders and on number one I'm going to write Defendant's Exhibit 2.

A. And on number two you will put [94] Defendant's Exhibit 3.

(Whereupon, Defendant's Exhibits 2 and 3 were marked for identification.)

Q. We'll put a tag on them later and counsel have agreed that these will be reproduced by counsel of the plaintiff and made exhibits in mass. First thing in Defendant's Exhibit 2 is the employers health insurance plan, State of Alabama, which, to which we've previously referred.

A. Right.

Q. You have placed on the front of that with scotch tape your eligibility card dated 10-1-82, is that correct?

A. Right.

Q. Did you have a similar card for preceding periods?

A. I'm sure I must have.

Q. And you have previously testified that you examined a portion of this booklet—let me withdraw that and let you tell me again, whether or not you have read this booklet and if [95] so when you did.

A. As I recall, what I have stated earlier, was after presenting some claims up at the South 20th Street office and being shown that particular provision, I procured a copy of the then current, now current, I assume still in force, certificate or explanation, pamphlet type of thing that you have in front of you, of the employee's health insurance plan.

Q. And so that would have been sometime after October the 1st, '82 or do you know?

A. Yeah.

Q. All right. Prior to that time had you read the contract between Blue Cross and the state?

A. You mean the contract itself?

Q. Yes.

A. No.

Q. Had you read anything?

A. One of these things, one of those phamplets.

Q. Is that all you had read?

A. Yeah.

[96] Q. Is that all you have read to date?

A. Well, I have seen that contract on the occasion I described earlier this morning, but just with the particular reference to the provision about the claim limitation three hundred sixty-five day period.

MR. RUTLEDGE: Again, just for clarification it would call for—excuse me.

(Recess.)

Q. Judge, so, if we can get a complete answer, as I understand, the only document that you have read relating to any type of contractual relationship between Blue Cross and the state employers insurance board or the state employers health insurance plan——

A. And me.

Q. Or you, with the exception of that limited perusal at the south side office, is this booklet that I'm——

A. I have stated that three or four times.

MR. RUTLEDGE: Wait a minute.

Q. Your counsel disagrees.

[97] MR. RUTLEDGE: Are you excluding from that reading my client and I visiting together and going through a various document, because if you include it I'm going to instruct him to exclude it from his answer.

Q. I'm including any document you have read, any contractual document you have read.

A. I——

MR. RUTLEDGE: We'll not include interviews with me in which documents have been reviewed in any answer or have not.

A. No, I wouldn't tell you about that.

Q. You wouldn't?

A. No.

Q. Don't think that is personal?

A. That is my lawyer's work and me working with him.

Q. What I want to know, quite frankly, is what knowledge you had of the contractual relationships between the defendant and the state before you filed this complaint on behalf of all state employees.

A. I had information about it and it [98] turned out mostly accurate.

Q. What was that information?

A. I haven't done it from documents.

Q. Where did you get that information?

A. People.

Q. Who?

A. I don't know. But when I got kind of interested in this I started——

MR. RUTLEDGE: Wait a minute. Let him ask you another question.

Q. Go ahead and tell me where you procured any information that you had that forms the basis of your complaint.

A. I couldn't tell you other than here and there.

MR. RUTLEDGE: Once again, are you excluding informaton that I have gathered following in the course of preparing the complaint and prosecuting this case?

Q. No, I am not excluding that.

MR. RUTLEDGE: Let me say this, that we are not going to voluntarily testify about interviews and what was done following [99] interviews prior to the preparation of the complaint and information that I have given the judge and the attorney/client privilege, either. If that is what

you are after, then you will have to get that some other way than a voluntary answer on this deposition.

MR. SIMPSON: Let me state that it is pertinent in determining whether or not he is an adequate class representative as to when and what investigation he has made as to the allegations involved in the complaint.

MR. RUTLEDGE: It seems to me, Henry, that if information was obtained as a result of my being retained to look into this matter and that I obtained information and share it with the judge, then that attorney/client relationship, that that is not discoverable by you and I would reluctantly insist to know that point.

Q. And you are instructing him not to answer?

A. I won't answer whether he instructs me or not.

[100] MR. RUTLEDGE: If you want to ask him what information he has obtained from other persons outside of that attorney/client relationship, fine, but of course, I am not going to tell you, have him sit here and tell you what my investigations have revealed in the course of preparing this case, of course, I am not.

MR. SIMPSON: Well——

MR. RUTLEDGE: Class action or no.

Q. I'll insist on an answer and I understand that you are not going to answer, is that right?

A. No, because——

MR. RUTLEDGE: No, just say no.

A. No.

Q. I'll ask the question as phrased by your counsel. What information have you received from any other source other than from your counsel concerning the allegations in the complaint?

A. I got leads from people that I put him in touch with.

[101] Q. Tell me who you talked to and from whom you received those leads.

A. I didn't talk to anyone.

Q. Did not talk to anyone?

A. I had people communicate with me.

Q. You received the information from some source, would you tell me what the source is?

A. I got a letter from a fellow, I don't remember who it was, but I turned it over to the lawyer and he followed up on it.

Q. Was this after the time of the complaint?

A. Yes, it was.

MR. RUTLEDGE: Well, we are not going to break down that sort of thing. I'll just, in order to make the record perfectly clear if you want the court to review it, I do not intend to allow the judge to voluntarily testify about when we had interviews and how we developed our case and who we talked to, either. If you want that then that will have to do it another way.

Q. I understand counsel's position and [102] what you have said you are not going to let him testify about what he knows about the allegations and complaint.

MR. RUTLEDGE: That is not what I said.

MR. SIMPSON: I'll come back to it. I'm going to insist on the question as phrased.

Q. Judge.

A. Yes, sir.

Q. We got into this by my asking you if you had ever read any of the contractual documents between the state

employees insurance board, employees health insurance plan or any state employee and defendant in this case. I'll ask you that question again and I'll first limit the time to prior to the time that you filed the complaint.

A. Documents?

Q. Yes.

A. No, personal, no.

Q. And did you have anybody read a document to you?

MR. RUTLEDGE: I instruct the witness [103] not to answer that question to the extent that it involves conversations between witness and me within the attorney/client privilege.

Q. Prior to the filing of the complaint did anyone read to you any contractual documents?

MR. RUTLEDGE: Again, same instructions.

Q. The second item in Defendant's Exhibit 2 is simply an adding machine tape. Do you——

A. Oh, that came out my little old thing. Who in the hell are these people? This is my handwriting. Oh, I know now what that note meant.

MR. RUTLEDGE: Are you asking about the adding machine tape or something else?

A. There hasn't been a question, he just showed me. You can clip it to it or scotch tape.

(Off-the-record discussion.)

(Whereupon, Defendant's Exhibits 2-1 and 2-2 were marked for identification.)

[104] MR. SIMPSON: Counsel have agreed that with respect to Defendant's Exhibit 2 we'll attempt to put in the bot-

tom right hand corner of each document a 2-1 so that we can refer to these serially at some later date.

Q. I show you what has been marked as 2-2, Judge, and ask you if you can explain that to me?

A. It's a so called claims summary on Blue Cross' form with some notations in my handwriting which appear on it.

Q. And the first thing that appears to be in your handwriting is the date of March 9, '83, is that right?

A. Now, and that is about the time she was diagnosed as having cancer, she being my wife.

Q. And you note that you received a check in the amount of three hundred eleven dollars and forty-three cents?

A. The check was in payment of prescription medicines.

Q. All right.

[105] A. I think entirely. And that is Ritch's Pharmacist is what that is.

Q. Is it accurate to state that everything that was printed was sent by Blue Cross and everything that is there I think you prepared?

A. That is exactly right.

Q. There is a statement in Blue Cross' print that the claim was processed on March 3rd, 1983. Is it your understanding that that is on or about the date that you submitted the claims that are reflected on this 2-2?

A. No it would have been submitted before that time.

Q. Do you have any judgment as to how long?

A. No. The information I put on it obviously relates to what the monies, three eleven thirty-four totaled partial reimbursement of and I'm pretty damn sure you have to exclude the bottom of it, I think positive these were for medications because it shows right here.

Q. All right.

[106] A. That is the 2nd of January of '83.

Q. And of the amounts of the prescription medications, that is the first three items that you submitted you were paid eighty percent?

A. Yeah, looks like it. I don't have any calculator.

MR. RUTLEDGE: That can't possibly be right of this figure right here.

MR. SIMPSON: Well, Gene, we are talking about the top three.

A. That is——

Q. The thirty-two dollar hospital stay. Now, Judge, the first one shows April '82 through August 9, '82. Were you in the habit of gathering up and submitting a group?

A. Usually quarterly.

Q. Was it your recollection that you did submit at one time a group of pharmacy charges that range from April 6th, '82 until August 9th, 1982? You can refer to your notes.

A. You will see a pattern. I would have to go through each of them to show you that [107] pattern.

Q. And if you do want to refer to any other document——

A. I don't need to at this point.

Q. Is it your recollection that you did submit a group of charges that incurred between those two dates?

A. I can only rely on what they put on it, but I don't have any independent recollection.

Q. With relation to the fifty-seven dollars and fifty cents charge for which you were paid forty-six dollars or eighty

percent thereof, do you claim that you should have been paid the entire fifty-seven dollars and fifty cents?

A. No.

Q. Do you claim that you should have been paid that amount before you were paid?

A. You are damn right, long before.

Q. Do you have any judgment as to when you submitted that claim?

A. It's on there, 1-25-83.

[108] Q. You have a note here that, in your handwriting 1-25-83, claim three hundred thirty-one dollars and sixty-nine cents, Ritch's.

A. For medicines, medications furnished to my wife. And a different amount submitted on the same day, those prescription medications.

MR. RUTLEDGE: Again Ritch's is?

A. Ritch's Pharmacy, Mountain Brook.

Q. And you have in your handwriting those two amounts, both for the period April 12 '81 to December 31, '82, would that be the period in which all of those pharmacy charges shown on this exhibit were received?

A. Must have been because it conforms with the dates that Blue Cross put on.

Q. Well, the latest date on the Blue Cross is November 20th, '82 I know, but see, this was through the period 12-31.

Q. In other words what you are saying is that there were no charges at Ritch's between November 20th and December 31st, '82?

A. Oh, yeah, but see, the form that they furnished me, take them to the pharmacist, he [109] gets the bookkeeper to fill it out and then he signs the whole list of it.

Q. Do you know whether, when those claims were submitted whether they were broken down between you and Mrs. Embry?

A. Yes, they sent one back because it wasn't broken down.

Q. So, insofar as any claims that are reflected by Exhibit 2-2 are concerned, your claim for damages is that you should have been paid in a more timely fashion?

A. Well, whatever my complaint complains of in that regard.

Q. It's not very particular?

A. Isn't required to be in the present system.

Q. I think I have to ask my client to find out what the facts are. You have three subcategories of claims, A, B, C in count one of your complaint?

A. We have did, too.

Q. D is for premiums, we'll get to that later. A says that you weren't paid, B says you [110] weren't paid the full amount and C says you weren't paid in a timely fashion. Can we agree that 2-2 relates only to subparagraph C?

A. I suppose so, looking at the allegations and looking at this one particular document.

Q. Any time you think you need additional documents that are available——

A. Oh, hell, I have been through those for years.

Q. I'll mark this number 2-3 now.

(Whereupon, Defendant's Exhibit 2-3 was marked for identification.)

A. Okay.

Q. And I'll ask you if you can categorize those claims as being, whether you suffered any damage as to result of any of the claims reflected on 2-3?

A. I couldn't answer that without reference to Blue Cross records because I didn't make a notation on this when I mailed it in.

Q. All right. You noted that you received a check on March 1st, 1983?

[111] A. Dated the 24th of February.

Q. All right. And that was in the amount of seventeen thousand fifteen dollars and seventy-three cents?

A. Right. It appears shortened three hundred eleven dollars and thirteen cents.

Q. Do you know how you derived the figure?

A. Not now I can't because this was—obviously I made these notes about the first or second day of March of '83.

Q. It appears that you were paying eighty percent of the amount of claims you submitted, does that coincide with your recollection?

A. It could be except I have got this figure down here, 3-11, three thirty-three that I added to the check, so——

Q. Do you know the basis of that figure?

MR. RUTLEDGE: Your Honor, if you don't know, you don't know. You are not required to sit there and try to figure it out.

A. Hell, that is a year and a half ago.

[112] Q. Do you have available to you any information, of any kind which would assist us in determining whether the information showed on Exhibit 2-3 represents a claim for damages that you are seeking in this case?

A. It would be in Blue Cross' file.

Q. Are you aware of why eighty percent of the claims are paid?

A. That is under major medical.

Q. Does that relate?

A. Accept they pay a hundred percent after a certain figure and I don't recall what the figure is.

Q. And that relates, among other things, to all pharmacy charges, is that right, they are covered under major medical?

A. I don't know if it's pharmacy or not, probably was. I can't tell, you see, because at that time I wasn't keeping copies of physicians' services. I now xerox them before I mailed them in.

(Whereupon, Defendant's Exhibits 2-4 through 2-8 were marked [113] for identification.)

Q. Now, on Exhibit 2-4, is this a copy of a letter you mailed?

A. January 25th, '83 written by my secretary in Montgomery, Mildred Gandy.

Q. And can you show me in this file what was enclosed with that letter?

A. That goes back to what ever documents were submitted on the first thing you referred to, which showed it was submitted on the 25th of '83. See, that coincides with the date on this copy of the letter to them, forwarded to them.

Q. So that would reflect that you at least dated the letter January 25th, 1983?

A. Well, that is why I said claimed at that date, see.

Q. You have—do you have any judgment as to what you consider to be a reasonable time for the processing of a completely accurate claim that you submitted to Blue Cross?

A. Well, I'll say this, some of these have not, none of these were inaccurate and I would consider that their own rule about the [114] seven days should apply, but even giving them two weeks, certainly three months is reasonable, in my judgment.

Q. Does your claim for delay encompass a claim for loss of use of the money?

A. Well, it also includes claims for interest from the damn money, from the date that was filed.

Q. Until when?

A. Until it's paid.

Q. You think there should be any period in there for processing the claim and mailing?

A. Seven or eight days, maybe two weeks even.

Q. Let me show you what is marked 2-5 which appears——

A. That is 2-5 are you looking at?

Q. Yes. This is a pharmacist claim form. Is that signed by you?

A. Yeah, that is for medicines furnished me.

Q. And that is dated January 25th, 83. Would it——

[115] A. That coincides so that must be a copy of the pharmacist claim made at that time, claim for pharmaceutical.

Q. And that is from Rusco Company in Montgomery, Alabama?

A. Yeah.

Q. And——

A. These all with the exception of one, coronary type medication and, well, decongestant, ulcer deals, Tagamet.

Q. And the date of purchase of the drugs that you submitted a claim for is shown as being——

A. Came from the pharmacy.

Q. And that would be May the 11th, '82 through August 18th, '82?

A. For Price Drugs.

Q. And 2-6, are those drugs from Price Drug Company for your wife?

A. Yeah.

Q. Submitted on January 25th, '83?

A. Yeah.

Q. And——

[116] A. Original was signed. I just made a notation to show the date. The original was signed by me as subscribed.

Q. And they show that these were for your wife?

A. Right.

Q. The purchases from April 6th, '82 to August 9th, 1982 in the total amount of fifty-seven fifty according to your records there?

A. Yes. Analgesics.

Q. And that was before your wife was diagnosed as having cancer, is that right?

A. Oh, yeah.

Q. And 2-7, '83?

A. Ritch's Pharmacy.

Q. That is for her in Mountain Brook?

A. For my wife, back stuff.

Q. And the date of the purchase ranged from May 7th, '82 to November 20, '82?

A. Right.

Q. And it was submitted on June 25, '83?

A. Thirty-one sixty-nine.

[117] Q. That is the total?

A. Right.

Q. If I can take you back to 2-5 and 2-6 on the notice verified by the pharmacist on June 12th, 1983, is that correct?

A. Well, what are you talking about 2-5?

Q. Exhibit 2-5.

A. Oh, excuse me. Apparently that is what appears. Mr. Boatwright, the pharmacist signed it and dated his signature as of the 12th of June, '83, I take it, and put the drug store tax identification number on it. That is Price Drug, Montgomery.

Q. Now, do you have any explanation as to why that date of June 12, '83 and subsequent date that you submitted on January 25th, 1983?

A. No, I don't. I didn't notice it. That ain't June, that is January, 12th of January on the front. Your eyes is as bad as mine. I caught you there.

Q. I asked you if you had an explanation, and you do.

A. It's January, it ain't June.

[118] A. Okay.

A. You are playing with me.

Q. If you can qualify me how much money you are claiming under any of these A's, B's and C's we can dispense with it.

A. You alerted me when you said June.

Q. I thought it was June.

A. When you asked for an explanation, there it is on the paper. Titch, titch.

Q. You are showing signs of impatience?

A. No.

Q. I'm going to tell you——

A. No, I'm restless.

Q. I understand.

A. I don't sit still this long. I'm usually passing in front of the jury.

Q. Wait a minute. You have been on the bench for ten years.

A. Well, I'm pacing behind the bench mentally.

Q. I want the record to review the comments by the counsel to reflect that you can not tell me, qualify in dollars the amount you [119] are claiming under the subparagraphs A, B and C.

MR. RUTLEDGE: That is inaccurate. If we had been requested in his interrogatories or in some request for production at this deposition to produce in the amount we claim or itemization of what we claimed, then the same would have been prepared. None of that has been done. The judge has been asked off the top of his head what these figures are. I'll tell Mr. Simpson now that if he would put such a question in appropriate form we will not only tell him, but chart it for him.

Q. Well, can you, do you want to phrase the question, I thought I asked him——

MR. RUTLEDGE: I don't think it is reasonable in a situation involving as many claims as this over a period of time such as this to ask the judge for a figure under compila-

tion. Go ahead with what you are doing. If you want to ask this in an interrogatory or some other format where we have a chance to compute it I'll be glad to do it for you. I'll take it back, I would, you know, be glad to do [120] it, I will do it.

A. All right. 2-8.

Q. Exhibit 2-8, Judge, after that, what I take to be as a no quicker better way available to us at the present time, in terms of what claims you are making?

A. Within a mathematical calculation, which I am not prepared to do.

Q. I am not so sure it's that easy.

A. Plus others.

Q. This is another form from Ritch's Pharmacy?

A. No, it's just a continuation.

Q. Two pages?

A. Two pages.

Q. And total five hundred seventeen dollars and ninety-five cents?

A. Right.

Q. Prescription drugs?

A. That is correct.

Q. Purchased?

A. Furnished to me.

Q. Purchased for you. Judge, that [121] covers a period from April 23rd, '82 through December 29th, '82 that you purchased those drugs.

A. Right. Do you want to know what some of them are?

Q. I count seventeen different varities of prescriptions.

A. I don't know how it's broken down.

Q. Do you know how many claims during this period from September '82 up through the filing of the complaint, how many claims you have filed?

A. No.

Q. On your behalf or your wife's behalf?

A. No.

Q. It is accurate to state that many of the claims such as the one we are looking at now had multiple drugs and procedures on one claim, did they not?

MR. RUTLEDGE: Object to the form.

A. Sure. Different ailments.

Q. Now, we come to a number of smaller size——

[122] A. Well, they are individual receipts.

Q. Individual receipts?

A. Or bills, copies of bills.

Q. And I'm going to number them.

(Whereupon, Defendant's Exhibits 2-9 through 2-15 were marked for identification.)

Q. I have put 2-9 through 2-15 on these. And, Judge, these——

A. What are they?

Q. You tell me what they are.

A. They are copies of third and fourth copies, of course, the third copy is submitted to Blue Cross, of statements that are returned with the medications from retired persons pharmacy, the old folks pharmacy, that medications are much, much less expensive there than they are elsewhere. So it represents a savings to Blue Cross.

Q. And those were purchased in St. Petersburg, Florida?

A. Well, that is where maybe you got the St. Petersburg. They are shipped by us or [123] mailed from St. Petersburg.

Q. You ordered them by mail?

A. The pharmacist served this area is a St. Petersburg, Florida type person.

Q. And you ordered these by mail?

A. Yes.

Q. Do you send in a prescription?

A. Yes. And the number of refills allowed, which the doctor marks on it and then they send you a copy of a form they have that shows you your next refilling, you are entitled to get it and how many you have left before you get a new prescription. It's a records keeping thing.

Q. And is the date that is shown in the right hand corner of each of these, would that have been the dates, the approximate date?

A. Probably the date they ship them. That is when they fill the order and put it in the process of shipping.

Q. And those run from August of '83 through December of '82?

A. If they are in order they appear to [124] be correct. If the earliest one is an August date and the latest one is December.

Q. All right. And were those submitted with your January 25th, 1983?

A. No, I would have to take the calculator and see if that is what went with this.

(Whereupon, Defendant's Exhibits 2-16 through 2-24 were marked for identification.)

Q. The next exhibit, 2-16 says see attached four hundred sixty-eight dollars and fifty-five cents?

A. I don't know, but I would venture to guess that if you added those that were prescription drugs on the forms you would find that it sums out to the figure on 2-16.

Q. And again you have dated that claim form 1-25-83, is that right?

A. Yeah.

Q. And here is another claim form?

A. Jesus. That is the claim they batted around for months, the thirty-two dollars for [125] x-rays.

Q. This, can you tell me why that batted around for months?

A. I don't know, because the doctor, what is the orthopedist, been around a long time over at Brookwood Professional.

MR. RUTLEDGE: Wise?

A. No, hell. John Higginbotham made those x-rays to do some study on that spine to see if there was anything he could do for her and he filed a claim and I didn't.

Q. Judge, look at 2-17.

A. All right. Thirty-two bucks.

Q. The second page of 2-17 it refers to the same claim, is that right?

A. Yeah.

Q. What you are saying is that Dr. Higginbotham submitted it and you submitted it?

A. I later submitted. That claim was paid, oh, six or eight months later.

Q. All right. Is the first page of 2-17 where you see thirty-two dollars see attached, that is not, is that when you——

[126] A. That is the second page, which was attached, but the original of it, this is a Xerox, as you can tell.

Q. The second page of it has some typed material and some things that are crossed out on it. For instance, apparently the original claim is submitted, had your name as John Embry, is that correct?

A. Yeah, that is filled out by the Brookwood Medical Center.

Q. And they submitted the claim in the name of John Embry, is that right?

A. I don't know whether that is right or not.

Q. Well, you received a copy of it from Dr. Higginbotham?

MR. RUTLEDGE: Counselor, how does he know that the John wasn't marked out and put in before somebody else sent it in?

A. I don't know.

Q. Weren't you told that the claim was submitted by Dr. Higginbotham's office with the name John on it?

[127] A. No, I wasn't told a damn thing.

Q. You don't know either way?

A. All I know is it wasn't paid until many months later. I'll admit it's a small item, but hell.

Q. It doesn't have the contract number filled in on the second page, which is exhibit 2-17, does it?

A. It's on the first page.

Q. The first page was submitted on January 25th, '83, wasn't it?

A. Yeah.

Q. This one was forwarded on August three, of '82 did not have the contract number?

A. Well, x-rays were made on the 23rd.

Q. Of '82?

A. Right.

Q. And it has a date forwarded?

A. I presume to the insurance company.

Q. It says signature of hospital representative, D. Reynolds, August 30, '82. And you finally got paid for that or did Higginbotham get paid for it or did both of you [128] get paid for it?

A. No.

Q. You don't know?

A. I paid Dr. Higginbotham in the interim and this was paid sometime in the spring of '83.

Q. It has on the second page of this, the complaint form has the date of August 30th, '82, the words written in your handwriting?

A. Yeah.

Q. Not accident?

A. Right.

Q. Now, do you know whether those were written in when it was originally submitted?

A. No. When they bounced it and kept asking for damn fool information about the accident. It's obvious from the form that it wasn't accident, low back pain with sciatica

and they have a history on it from the computer of years and years of back trouble nonrelated to any trauma, accident trauma of any nature.

Q. All right. Do you have any knowledge as to why that information was required in the [129] process of the claim whether or not it's an accident?

A. Sure.

Q. Why?

A. It would be a legal conclusion, but your own requirement, Blue Cross' own requirements, is all I know.

Q. I'm asking if you have any knowledge for the basis of that requirement?

A. No, not any real knowledge, just conclusions.

Q. Judge, it is clear that the words not accident are in your handwriting?

A. Sure.

Q. Is it not also clear that the word Eric is penned in as your printing?

A. I printed that in.

Q. That was after your submission of the original claim?

A. Oh, yeah, January 25th, '83 when I resubmitted.

Q. Are you claiming any damages in this suit, any portion of that?

[130] MR. RUTLEDGE: Hold up just a minute, please.

Q. Judge, I'm going to restart that question, Mr. Rutledge had to leave the room. Are you claiming any damages as a result of the delay in payment of that thirty-two dollars?

A. You damn right I am. Let's see the complaint. It

would be under one of these categories, A, B, C, D. A through C.

Q. All right. Well, can you—it's not failing to pay entirely, is it, we can eliminate A?

A. You can reach your own conclusions there. If it takes all, page nine of the complaint, till finally you can see that I got a check for thirty-two dollars, and whatever that interim period, you could include that if it—that it wasn't paid or you could include that it was a terrible long time before it was paid.

Q. Is there a distinction, and I don't want to jump ahead entirely, but is there a distinction in your mind insofar as the bad faith claim between a failure to pay and delay [131] in payment?

MR. RUTLEDGE: Your Honor, if you will wait just a minute. That is going to be a matter of law, and whatever distinction he draws in his own mind will be totally irrelevant.

A. That would be up to the law, the judges and you lawyers.

Q. Well, are you?

A. To argue that out——

Q. Are you claiming any punitive or exemplatory damages as the result?

A. Does the complaint say?

Q. In count two it does.

A. Then I am claiming.

Q. What I'm asking you, with respect to the claim of thirty-two dollars, is that shown on exhibit 2-17? The complaint isn't that specific, unfortunately.

A. It doesn't have to be.

Q. I understand that.

MR. RUTLEDGE: Although, we are not agreeing it isn't.

Q. Are you or aren't you recommending [132] exemplatory damages as a result of this claim?

MR. RUTLEDGE: We are where such are accessible by law where the facts develop exemplary damages are due based on the facts, then we are claiming those damages.

A. Very well answered.

Q. Do you have any other different answer?

A. No, he is my lawyer.

Q. I'm asking for facts. You are the one who is seeking money.

MR. RUTLEDGE: This ain't a fact. That is the matter of taking the facts and applying them to law.

A. Get to the bottom line.

Q. Do you say that is typical of all of these claims?

A. What is typical?

Q. This thirty-two dollar claim?

A. What do you mean by typical?

Q. Is it typical of your other claims?

MR. RUTLEDGE: You mean the delay parts?

[133] A. It's a typical type claim, yes, of other people and myself.

Q. What other people?

A. Members of this class.

Q. What knowledge do you have of those?

A. Nothing other than the pattern that has been shown to date by the conduct.

Q. What facts do you have upon which you base that answer of the conduct relating to other people, any?

A. I can only deduce.

MR. RUTLEDGE: You will have to exclude from your answer——

A. I know, what information you furnished.

MR. RUTLEDGE: That is correct.

A. But me personally, I could only deduce or conclude from the pattern of conduct exhibited in the instance of my late wife and myself claim, it's got to be a pattern, and from Mr. Thrasher's testimony.

Q. Those are the two sources?

A. Yes.

[134] Q. Have you talked to any other members of the class who has given you any information, I'll strike the word class and say any other state employee present or retired?

A. Yes.

Q. Who have you talked to?

A. Numerous ones have read about the lawsuit and read some of the details and said that is typical of the way I have been treated and that was in generalization, of course.

Q. Have you been interviewed by the press about this lawsuit?

A. No, I don't give interviews to the press, as a lawyer or judge or client. I don't believe in that. They can screw up anything.

Q. Even to the New York Times?

A. Mighty good client. I smile all the way to the bank despite all the abuse I took.

Q. Look at 2-18, Judge.

A. I'm looking.

Q. This is a claim summary generated by Blue Cross with a process date put on by Blue Cross of April 16, 1982 and it appears that in [135] this case you submitted——

A. I don't think this was something I submitted.

Q. No, this is generally about Blue Cross, and does it reflect that you have paid in full for—paid in full for the laboratory and x-ray charges that were made by Dr. Jane Day?

A. I think you will find that Dr. Jane Day in Montgomery, internship, managing me with Dr. John Stone at the time because we were staying in Montgomery, she very kindly, her office submitted these charges and I would get the check and I would pay her or I would have paid her already and then when she made the claim and they would send me the check. That is how I recall it.

Q. You have written on here in your handwriting Bedford?

A. That is for Bedford. She went to her, too. We lived in a little place right from our backyard to her backyard and I could go over there in my robe and slippers.

Q. In her house or her office?

[136] A. Her office is in a house there on Adams and we were on South Bain and they cornered each other across the lot.

Q. Let me ask you——

A. Her office hours was six a.m. till noon.

Q. May I ask this question?

A. Sure.

Q. Are there any charges related to your treatment by

or Mrs. Embry's treatment by Dr. Jane Day that weren't paid in full on a timely basis?

A. I don't—I can't, you know, my recollection ain't that good as far as the timely basis.

Q. This indicates that some laboratory work was done on April 6th, '82?

A. Yes, wait a minute. There were some charges for lab work that Dr. Day sent to another lab. She had a lab in her office with a few basics, but some of this blood work stuff, on either me or Bedford, I believe it was Bedford had to be sent to another place and that [137] got screwed up and we had to horse that thing around a while, as I recall. That wasn't this forty-two dollar check.

Q. Then, I'll ask you to look at Exhibit 2-19 and is it a photocopy of 2-18 with a check thank you received from Blue Cross?

A. Right.

Q. By April 16th, '82 had you taken to photographing the checks you received?

A. Occasionally, if I felt it was significant, and why I felt it was significant at that time, I don't remember.

Q. But does that indicate that for work which was performed by Dr. Day?

A. In her office.

Q. On April 6th, 1982 that you received a check dated April 16th?

A. Yeah.

Q. And that was in full amount of the laboratory charges, wasn't it?

A. I suppose so, if this adds up here, charges submitted, if that is forty-two dollars, then this is forty-two—no, wait a minute.

[138] Q. The medical care is for thirty-five dollars was applied against your doctor bill?

A. I don't know. I'm confused at this point.

Q. Do you have any judgment as to when you received that claim sent, that check sent to your Birmingham address dated April 16th, '82?

A. The date, the check is dated 4-16-82. If it had the usual delay en route it would have been received a week, ten days later in the mail.

Q. Did you have any—how many days at a time would you spend in Montgomery during that period of time?

A. In '82 usually about four, sometimes five, sometimes seven if we were going to have oral arguments, whatever.

Q. Did anybody pick up your mail at your home?

A. Yeah.

Q. Who would that be?

A. My—in '82?

Q. Yeah.

A. My daughter would do it and I had a [139] staff attorney, well, no, I had a law clerk, '82, it was picked up and put inside the house. Of course, the envelopes had post marks on them. I didn't keep the envelopes.

Q. But nobody deposited them to your account for you or endorsed them for you, did they?

A. No, I did that myself.

Q. Look at number 2-20, which is also Blue Cross claim summary with a process date of April 1, '82. The first item on it is for eighty dollars and sixty-one cents and there is a notation there, time limit exceeded for filing these services?

A. I guess that is when they threw that claim limitations thing. I have to assume that.

Q. Did you have any discussion with anyone there?

A. No, I gave up calling those people years ago.

Q. On those particular charges it indicated they covered services rendered from January 9, 1981 and February 6, 1981. Would [140] that comport with your recollection?

A. I don't have any independent recollection about it.

Q. Do you have any recollection of what those were?

A. Since physically they are in here adjacent to, unless this has been shuffled around, and I don't think it has, recovering of a back brace and putting another corset on, that is what they call the thing you lace made out of canvas or something at Smitherman's and for Bedford and at Durr Surgical Supply for me—no, that is blood pressure unit I got. The brace thing, as I recall, I don't know. One of these was one that had to do with—this was me, patient on 2-20, Exhibit Number 2-20. I was the patient, so these were charged and related to me. When was this, '81. This had to do with cardiac stuff.

Q. June, is it a fact that you did submit claims for either services or other medical items which were, where the services for which the charges were rendered were more than a [141] year old?

A. They took that position and, hell, I, you know, I got to the point I couldn't take all this time fussing with these people, I had my duties to perform.

Q. Well, is it your position that, and are you seeking in this suit any damages for medical charges rendered more than three hundred sixty-five days but before the filling of the claim?

A. Well, I can't answer that in that fashion because see,

some of these things had been incurred and some initial notice to them had been made, but the time limit thing on three hundred sixty-five days ran while we were jockying back and forth on it. And then this damn thing here.

Q. Referring to the second item?

A. Was absolutely inaccurate because I never submitted any claim. That is some of that gobbledygook about not related to the diagnosis and, hell, I had all kind of diagnosis listed by the doctor and every one of them related to [142] something that had been diagnosed.

Q. You are referring to the second item?

A. Yeah, four hundred fifty-six dollars and seventy-five cents.

Q. Let me get you to answer my question on the first item, and my question is this, now, listen to it, are you making a claim in this lawsuit for damages which you suffered for claims submitted to Blue Cross the first time more than three hundred sixty-five days after the service was rendered to you?

A. Not if at that time the provision relating to claims limitation that was in the contract because obviously that wouldn't be a valid claim. It would be the statute of limitation, contractual limitations. I can't claim anything illegally, I don't suppose.

Q. Well, the first part of Exhibit 2 is a book dated October 1st, 1980 which has that provision in it, which you showed me. Do you have any reason to believe that that was not a part of the contract?

A. No.

[143] Q. Do you have any knowledge as to the genesis of that provision in the contract?

A. Yeah. I have been told.

Q. What have you been told?

A. The claims like I described to Judge Almons for his wife whom died some years before, he didn't know he should have made a claim and he recovered several thousand dollars, I recall. And then that comes, I think the direct result of maybe his and other people's claims they put that limitation period in there.

Q. Who put it in there?

A. Blue Cross. That is where it is, in the Blue Cross thing.

Q. Is it your understanding that that is——

A. I didn't put it in there, that is for damn sure.

Q. Do you think the State Employees Insurance Board did?

A. That is a question of law as to who in the hell does those things under this setup you have.

[144] Q. Did you ever discuss that provision in the contract with any member of the State Employees Insurance Board?

A. No, I never discussed anything with them.

Q. Now, you wanted to talk about the second item on 2-20?

A. I don't want to talk about it, I just mentioned that.

Q. Well, you mentioned, then, that there was a deduction of fifty-seven dollars from the four hundred sixty-five dollars and seventy-five cent charge for services not related to the diagnosis, do you have any idea what that relates to?

A. No idea.

Q. Are you seeking——

A. I don't care.

Q. Recovery of that five dollars?

A. You can have the five dollars.

Q. Would you agree to strike that?

A. Strike the five dollars.

Q. Now, the other charges reflected on [145] 2-20 other than the first two seem to have been paid——

A. No here is one here.

Q. You are right, I'm sorry, the——

A. You have to look carefully.

Q. Right, Judge. The fourth item also reflected charges that were over three hundred sixty-five days?

A. Time limit extended for services, thirty-six dollars and five cents.

Q. Your answer to that would be the same?

A. Sure.

Q. Do you have any reason to believe that those charges were submitted any time before the three hundred sixty-five time limit expired?

A. No, I can't say that. I don't know what these particular ones on this 2-20 are.

MR. RUTLEDGE: Exhibit 2-20?

A. Exhibit 2-20. I just, my recollection fails me. I was the patient and it's a pretty substantial charge there. I would just have to guess as to whether they are [146] doctors or prescription medication, in all likelihood that is what it was.

Q. Other——

MR. RUTLEDGE: Once again, I want to state for the record that whether Judge Embry says that we are going to claim

those charges were in or out of the three hundred sixty-five days will depend on what the facts depicted shows.

MR. SIMPSON: Gene, that is what I'm asking, is his judgment and recollection, any information he has about the facts.

A. Do you mind if I stand? I'm getting stove up.

MR. RUTLEDGE: Well, Henry, what I mind doesn't matter, but what I am suggesting to you is that you are asking about a claim that he does not presently possess information when it arose or when it may have been filed and I'm telling you that I don't want you to proceed on the assumption that claim won't be made because if subsequent records show that based on the contract language they were due to be paid, then [147] claim will be made for them.

Q. Sure. Judge, let's get back to the factual matters. The other four items on Exhibit 2-20 were eighty percent of the amount submitted was paid?

A. Apparently so.

Q. Do you understand why only eighty percent was paid?

A. I think that is the deductible.

Q. Are you claiming any damages for the failure to pay a hundred percent of any of those claims?

A. Depends on whether, as Mr. Rutledge has stated, whether it turned out later that we find that these should have been paid under basic or the amount of the limits in dollars had been exceeded and therefore they were payable a hundred percent major medical?

A. That is the only way I can answer.

Q. But do you have any information currently available to you?

A. You got it.

Q. I would like for you to answer my [148] question.

A. I said I don't, you have it.

Q. That is what you haven't said, you don't have any information which would——

A. Presently, no.

Q. Which would assist us in determining whether or not this claim should be paid more than eighty percent?

MR. RUTLEDGE: As far as your question says currently available, and that includes our ability to procure Blue Cross' records, then I think that is what the judge is referring to.

A. That is right.

(Recess.)

Q. Judge, you have referred to 2-21, which is a back brace for Mrs. Embry in the total amount of——

A. That is to recover and put a new corset.

Q. Dated 12-22-81. Do you have any judgment as to when that was submitted to Blue Cross?

[149] A. No, not at this point and from independent recollection, no.

Q. Do you know whether or not you received payment for that?

A. At this time I can't tell.

Q. Would the checks related to Mrs. Embry's, Mrs. Embry as a patient, for instance, that back brace, would that check be payable to her?

A. No, it would be payable to the insured, me.

Q. Is that true in every case, you don't remember her ever getting a check?

A. No, I don't.

Q. Look at 2-22 which is, I don't know, two hundred thirteen dollars and forty-seven cent bill and do you have any recollection or can you tell me from reading that what that was for?

A. Yeah. I was, Dr. Day suggested I get a blood pressure outfit to monitor my own blood pressure and I got one of these electronic damn things in Montgomery and you could take it fifty [150] times back to back and get a different reading each time, so I had her calibrate it or check it against her mercury and she said that ain't worth a pinch, so I took it back. And this Mrs. Etheredge out there took the other one back and then I bought a regular cuff and a stethoscope, which I have at home now, and I taught my law clerk and secretary how to take blood pressure. It's not too reliable if you take it yourself.

Q. Well, then, what you have just described appears to amount to sixty-six dollars and twenty-eight cents?

A. I don't know how I came to those figures. That has got to be it, because this is the blood pressure unit, that is the dial and the cuff and this is the stethoscope and that is sales tax which is marked seven percent tax, sixty-six twenty-eight for two fourteen forty-seven was for that fool electronic thing that didn't work.

Q. Did you get full credit for that when you returned it?

A. We came out with a net figure, I [151] think what happened was I paid for the original, took it back, I know this is the way it happened, they gave me a refund after I had bought this one, they gave me a check that they drew out there at the place in Fairview Avenue.

Q. For one hundred forty seven dollars and nineteen cents?

A. Presumably that is correct because that is the differ-

ence in two fourteen forty-seven and two sixty-six forty-eight, if my figures were correct.

Q. Did you submit a claim to Blue Cross for that?

A. I don't recall it, but I'm sure I did.

Q. Do you know in what amount?

A. No, I don't.

Q. Do you know whether you were paid anything related to——

A. You will have to look through that file.

Q. You don't have any information?

A. Not independent recollection.

Q. Now, you have clipped together, [152] stapled together, let's do these separately because they'll be undone any way. Let's look at 2-23. Now, this is a claim summary, Blue Cross claim summary made May 25th, 1982.

A. Yeah, according to Blue Cross records.

Q. And your first charge is two hundred nineteen dollars and thirty-two cent charge?

A. Yeah.

Q. And there is deduction of sixty-five dollars and you were paid eighty percent of the difference?

A. I don't know.

Q. You don't have any idea what that charge is related to?

A. No. I think these documents to which are stapled might show it.

Q. You have written in your handwriting on here the name Mrs. Sheila Cooley?

A. That is the young lady up at the South 20th Street. Sheila something else and she went up and fool got married.

Q. Did she assist you, did you call her for information about this?

[153] A. At that time, as I testified earlier today, I would take these by and she would give me the claim form and put them all together and send them out to Riverchase.

Q. Are you claiming damages of any kind as a result of any conduct on the part of Mrs. Sheila Cooley?

A. Not Mrs. Cooley, no, sir.

Q. Did she handle everything efficiently?

A. Very effficient, very pleasant. When it goes out yonder, that is a different story.

Q. Look at number 2——

A. When it goes south.

Q. 2-24 and do you have any claim summary dated May 25th, '82, that you have any judgment?

A. No independent recollection what that is. These documents attached to it show that it's a major medical claim and somewhere behind it you will find something else.

(Whereupon, Defendant's Exhibits 2-25 through 2-30 were marked for identification.)

[154] Q. All right. Exhibits 2-25 through 2-30.

A. Yeah, yes, sir.

Q. Appear to be claim forms relating to 2-23 and 2-24, is that correct?

A. Appear to be, yeah.

Q. Now, is that your signature on——

A. Yeah, 2-25.

Q. Does it bear a date of May 20th, 1982?

A. It does that.

Q. Does that indicate when you submitted that claim?

A. Let's see, let me refer to the pharmacist thing to see what date. Sometime after the 2nd day of May because I—is all I can pinpoint and probably the 20th date with my signature indicates the date I mailed it in all liklihood.

Q. And that, the date, however, is in your handwriting, is it not?

A. 5-20.

Q. And in your handwriting here it says type of illness osteoporosis, et cetera?

[155] A. Wife.

Q. Total of this claim, two seventy-eight fifty-seven?

A. That is for Mrs. Embry.

Q. Now, then, there is a parenthesis, six hundred seventy-two dollars per both?

A. That is an aggregate probably of my claim and hers. There it is.

Q. 2-26 is a claim by you——

A. No, two seventy-eight, wasn't it, oh, you are talking about the number of the exhibit, excuse me.

Q. Exhibit 2-26 dated again May 20, '82 is a claim submitted by you for a total of four hundred twenty-three dollars and fifty-two cents, is that correct?

A. Is that for me?

Q. And then 2-27 is at Ritch's Pharmacy?

A. That is exhibit number?

Q. Yes, Exhibit Number 2-27.

A. Ritch's Pharmacy.

Q. And that is dated April 22, 1982, is that right?

[156] A. I presume that is 2-28, yeah.

Q. And it covers prescription drugs that you purchased there between the dates of January 9th, 1982 and March 31st, 1982?

A. Prescribed for me.

Q. However, the claim is originally submitted had your wife's name?

A. No, no, it wasn't submitted. This was xerox of the form that I at convenience used to—see, I got them juxtaposed so before I mailed them I struck mine in pen and put the proper name on it because it's different.

Q. Is it your recollection that you did that before it was submitted?

A. Oh, yeah. I know damn well I did.

Q. Or after?

A. I know I did it before.

Q. Exhibits 2-23 through 2-30 all, were they all sent on May 20th?

A. May 20th in all liklihood, I have them all stapled together. Must be for that reason, they are all related, filed simultaneously. That is another pharmacy on [157] 2-30. That is another pharmacy, for Price Drugs.

Q. And the pharmacist signed it May the 2nd?

A. Yeah.

Q. '82, 1982. From looking at Exhibits 2-23 through 2-30, are you claiming any damages, can you give me any information to indicate whether or not you are claiming any damages for failure to pay any portion of that claim?

A. Depends on what develops as to what the records show how soon I got my money, if I have got it under one of these three categories on page nine of the complaint, A, B and C.

Q. Let me digress and ask you, is there any one particular claim that you can tell me about that you know you didn't get paid?

A. That I know I didn't get paid?

Q. Yes.

A. The one that related to the—the one I can think of at the moment is that, the, oh, we referred to it back yonder, I don't know which one it was, we referred to it earlier in the testimony.

[158] Q. Dr. Higginbotham?

A. That was one, but, no, we were talking about another one. We've talked about so many things that relate today, I'm tired—it's getting late in the day, I'm tired.

MR. SOMERVILLE: Was it one of your wife's claims?

A. Here is a letter I find.

Q. Let's mark that as——

MR. RUTLEDGE: Do you include in your question current unpaid claims, Henry?

MR. SIMPSON: Yes.

A. There are some of those that haven't been paid. They are over a month old now.

Q. And that is what you are going to bring us information on in the morning.

A. I'll have copies of them.

Q. Looking, Exhibit 2-30 is a letter from you dated April 27th, '82 sent to Blue Cross, is that correct?

A. Yeah.

Q. And it refers?

A. Here is what it refers to. Let me [159] read that letter, if you would.

Q. Sure, Judge.

A. I'll have to take back an answer about Mrs. Cooley's negligence. I notice here that she put hypertension on the wife's claim form. That is my ailment. My wife had low blood pressure. Okay. Shoot.

(Whereupon, Defendant's Exhibits 2-31 through 2-45 were marked for identification.)

Q. Does your letter of 2-30, your letter April 7, 1982, which is marked Exhibit 2-30, did that enclose Exhibit 2-31?

A. This, they bounced back to me. That is not my handwriting. No, this is the one that Mrs. Cooley, see, she had put on Bedford's claim form, she volunteered that she would fill it out for me. She put hypertension, back and neck injury, hypertension. Well, hypertension wasn't applicable to my wife and she hadn't put anything about an accident on there. I added that after they bounced it back. And then I sent back to them on their letter of 3-22-82, [160] them being, it being Blue Cross, 2-32, patient name Embry, contract number, so and so, claim number. We are unable to process your claim. Please give date of accident, indicate if drugs were prescribed for accident, thank you. Then I wrote in when I sent it back, these are the same medications base, which followed back surgery from non-accident related herniated lumbar disk and attempted vertebra fusion, lack of which occurred—the last of which occurred 10-28-71. That is the date I couldn't recall. Medications for reimbursement for which you have paid, I didn't complete that sentence.

Q. You think——

A. I meant to say have paid in the past, for past medications, not the ones represented on that claim.

Q. Are 2-31 and 2-32——

A. All part of something I stapled together.

Q. And did they accompany your letter as exhibit 2-30?

A. Yeah, I sent them back corrected.

[161] Q. Does 2-31 bear at the bottom your signature?

A. Yeah.

Q. Did you sign it?

A. I had signed it in blank.

Q. Did you date it March the 9th, 1982?

A. No, you can tell that ain't mine. This is, all this other handwriting is Mrs. Cooley's, except heavy dark black ink which I corrected Mrs. Cooley's errors when they sent this back to me and sent it back to them with the corrections and with the notation on the bottom of the bounce back letter.

Q. Okay.

A. But the signature on 2-31, the bottom, even though it's in the light ink, is your signature, is it not?

A. Which I place—my signature which I placed on a blank form that I left at 20th Street.

Q. What form did you give to Mrs. Cooley to fill out that form?

A. Mrs. Cooley had the information.

[162] Q. What was it, was it bills or do you know?

A. Oh, it was what shows here as—I didn't keep a copy of the original was submitted by her, yeah. These were for drugs for myself and Mrs. Embry as their letter indicates.

Q. But the form is originally submitted to the Blue Cross claim center, had your wife's name as the patient?

A. No, no. The form that was left with Mrs. Cooley had my signature on it.

Q. And that is all?

A. That is right, and she, as I mention in the letter——

Q. But the form——

A. Very courteously offered to handle this for me.

Q. Were you in a hurry or do you recall anything else about that?

A. Yeah, I recall getting paid.

Q. Do you recall any——

A. I recall what I thought, if you would like to know that.

[163] Q. What did you think?

A. Just one more screw-up.

Q. Do you recall anything more about your meeting with Mrs. Cooley in which you signed a blank form?

A. I just asked her how was she getting along, how was married life.

Q. Do you recall her answer?

A. Said it's fine, but her father has a heart condition, he was a Birmingham Police officer and she took an interest in me because she couldn't get her father to behave himself. I smoke. I hadn't smoked at that time in about four years, since October of '78, no, December '78 and we had a little pleasant colloquy there, dialogue, whatever you want to call it.

Q. Anything else you remember about it?

A. No, she is a pretty girl, I remember that, very handsome girl.

Q. Any little other discussion about the substance of your claim that you remember?

A. I said, I think that I recall I said something like here are some more drugs, [164] periodic drugs for Mrs. Embry and myself, she said I'll take care of it, we got all the information and I left it. I was on my way to the office over at UAB.

Q. And what she filled in the form, the information you gave her had patient's name Bedford and type of illness, back and neck injury, hypertension, is that correct?

A. That is what she put on it.

Q. And then in the heavy black ink is what you wrote in?

A. After I got it back from Blue Cross and resubmitted it.

Q. And in response to referring that back you wrote your letter of April 7, '82 in which you threatened to sue, is that correct?

A. I certainly did.

Q. Is this, we've talked about the time in '68 that you threatened to sue, approximately '68?

A. Well, no, I don't think I threatened to sue. I didn't testify to that effect.

Q. That is——

[165] A. Are you talking about with the conflict with Miller?

A. Yes.

A. No, I didn't threaten to sue. I said it's a hell of a note, and it was a hell of a note.

Q. Is this April 7, '82 then the first time you threatened to sue Blue Cross?

A. Yes. I was getting a little tired of it, if you want to know the truth of it. As you can see, I didn't do anything.

Q. You mentioned the——

A. You see.

Q. Tortious bad faith?

A. I'm a bit irritated and I wish to inform you that unless the claims are paid I tortious bad faith and act accordingly, and I meant it and I have done it.

Q. And did you receive any response to that letter marked 2-33?

A. From Mr. Oglesby, yeah. I got that letter, yeah, I got it.

Q. Did Mr. Oglesby at that time tell you [166] that a portion of the claim which you had submitted was barred by the contractual provision that was more than three hundred sixty-five days?

A. That is what he said. Whether it was lying or not, I don't know.

Q. Just don't have any information?

A. No.

Q. Did he explain to you why he needed the information?

A. Well, the letter speaks for itself.

Q. From that time forward did you understand why it was necessary to know whether it was caused by an accident or not?

A. I just have—all I know is what he stated. I don't know what the truth is.

Q. Did he tell you that if you would file your claims as they occurred that your, that would help alleviate your complaint about holding the money?

A. Yeah, I guess that is what is in the letter.

Q. Is there anything in the letter [167] that——

A. File a claim for twenty-five, thirty, thirty-five dollars claim as they occur, I got better things to do than file individual claims every time I incur an expense, hell.

Q. Was there anything in that, was there any follow-up communication between you and Blue Cross about the subject matter of that particular——

A. Not until, what date did you file this lawsuit?

MR. RUTLEDGE: January of '84.

A. January of '84 there wasn't any follow-up.

Q. Well, let me ask you this, as far as you know was there any written correspondence between you and Blue Cross other than the submission of claims and the claim summaries which you received?

A. If there was it's in here.

Q. Do you recall?

A. I don't know. I haven't looked through that thing in recent months.

[168] Q. Did Exhibit 2-33, the letter enclose Exhibits 2-34 and 2-35?

A. Yeah, except copies that I made.

Q. And you did not dispute them any further at that time the amounts paid?

A. Well.

Q. As shown on 2-34 and 2-35, did you?

A. No.

Q. 2-26 is a letter to you dated March 19th, 1981?

A. Yeah.

Q. From Mrs. Holliness of Blue Cross?

A. I didn't know the Pope was married.

Q. In which she sent you copies of your major medical claims for the year '79, '80 and '81 through that date?

A. Yeah, secretary to E. Gene Chrysler, I don't know.

Q. Do you know what?

A. I don't know why they sent me this. I don't recall asking for major medical claims for '79, '80 and '81.

Q. Did you receive it with that letter?

[169] A. I don't know. If they are in here I got them.

Q. Do you have any recollection of asking for the claims?

A. No, I don't.

Q. Was there some other type of coverage or——

A. No.

Q. Plan available to you for which you could recover?

A. No. See, this is in '81 to date, see, that was in 1981, so that was back in—that was back and cardiac, respectively. I don't know.

Q. You don't have any judgment?

A. I don't know why that came up because that predates my letter of April 7, '82.

Q. Just taking them as I come to them.

A. I don't assume responsibility of whether these are in chronological order or in the——

A. I had them as in the file.

Q. Is 2-37 simply a xerox copy?

[170] A. Of that card.

Q. We find in here a card from Mr. Rutledge. Was he——

A. He wasn't soliciting my business.

Q. Just calling on you?

A. No, I called him.

MR. SIMPSON: Gene, do you want to remove that?

MR. RUTLEDGE: I don't know what it is. I stuck that on there to get the file.

Q. Exhibit 2-38?

A. Yeah.

Q. Is a claim summary?

A. Yeah.

Q. With the date at the top of December 1st, 1983?

A. What it appears to be.

Q. Do you know what that is?

A. Blue Cross-Blue Shield form, says claim summary and it's got a whole list of stuff and no payment except a hundred dollars for Bedford's outpatient x-ray, therapeutic x-ray. By this time, which had exceeded the, whatever [171] those limits are on dollars, so it paid a hundred percent.

Q. All right. There are six entrees on that?

A. Yeah, this is that deal where the claims for therapeutic x-rays injuries, that is when the group—the group out there threatened to sue me. I finally got these claimed then and this is what they put on it. Charges previously considered. It wasn't previously considered filed by me.

Q. You got this back? Did you get it back shortly after December 1st, 1983?

MR. RUTLEDGE: This being exhibit——

Q. 2-38.

A. That thing came in before Christmas because I was out of town on Christmas. That came in somewhere around the 15th.

Q. Of December, 1983?

A. In '83 Christmas was on a Wednesday and I left the City of Birmingham on the preceding Thursday afternoon.

Q. These are all, these being exhibits [172] 2-38 through 2-42, all have a date of December 1st, 198—I'm sorry.

A. That is that therapeutic x-ray.

Q. 2-38 through 2-41 have the date of December 1st, 1983?

A. You don't have a 2-42.

Q. It's dated December 17th?

A. Oh, that is previous. This is me, I think. No, that is Dr. William Howley and this was for September, see, this was last—the 15th of September she had gone to Dr. Howley's office for blood study and found the white blood count of zero, so he put her back in the hospital after the chemotherapy and that is when she died, the 20th.

Q. Do you have any judgment when these claims are reflected on Exhibit 2-38 through 2-41 were submitted?

MR. RUTLEDGE: May I just see those just a second?

Q. Do you remember the question?

A. No. When were they submitted, I think is what you asked me.

[173] Q. Yes.

A. At this time I can't tell when they were originally submitted because there were several submissions by different people, myself and the outpatient x-rays therapeudic group. And as I mentioned earlier today about their threatened suit because my account was way past due. It was a long story and you will have to get it question by question because I can't narrate it.

Q. Did you ever submit a claim for the same charges that are reflected on Exhibits 2- ——

A. Not until——

Q. 2-38 through 2-41?

A. —until I submitted and this was the response. I told you about it.

Q. This, in other words, is it your testimony that 2-38, the claim summary is Exhibit 2-38 was in response to a claim that you filed?

A. Ultimately I filed it myself.

Q. Do you have a copy of that claim?

[174] A. No, unfortunately back in those days I wasn't xeroxing the claims. Yeah, wait a minute, here is one but that is not the—that is for Dr. Howley's services there, so that is not, that is not the claim related to the therapeutic x-ray. Is that that stuff from the therapeutic x-ray forks, past due bills, yeah. When does that show. They billed me on the 18th day of August. That is one billing. Of course, they had these forms, you rip them apart. Some pink looking ones came later about the past due and all that crap. I should have said hell, go on and sue.

Q. That is what James A. Simpson told you to do in '68?

A. That is good advice I didn't follow.

Q. I'm going to mark what you have just referred to as 2-43 and 2-44?

A. We'll run out of numbers before long.

Q. And these show a bill addressed to you for services rendered to Mrs. Embry at Baptist Medical Center?

A. That is right. Of 7-7-83 notation to [175] date your insurance company has not paid on your account and that x-ray therapy had been going on since March.

Q. They sent that to you in August of '83 and a duplicate bill in September of '83?

A. Exactly. And then the pink ones came.

Q. Except as was——

A. After she was dead.

Q. Now, are those—does the two thousand two hundred fifty-nine dollars shown on 2-43——

A. Is that all of it?

Q. Does it include any of the charges that are reflected in Exhibits 2-38 through 2-41?

A. I can't tell because these statements were summary type statements, I call them, these statements from Baptist Medical Center for therapeutic x-ray, you see those that I find——what is this?

Q. That was an envelope so you could send your check back if you wanted to.

A. Oh, yeah. I don't know because this thing has gotten in a tight situation as far as [176] them wanting their money and Blue Cross had not paid them and——

Q. Well, is it your recollection that all or a portion of the bill reflected on 2-43 was for x-ray treatment?

A. Oh, it was, no question about that. I'm trying to get the first date that—well, the first date shown on Blue Cross' claim summary sent me, summary sent me.

MR. RUTLEDGE: Give the Exhibit Number.

A. 2-38. Shows—that form shows the June the 6th and you have to, our records indicate this charge was previously considered. It wasn't a charge that I had submitted a claim for. Apparently it was a charge that x-ray therapeutic baptist Medical Center had submitted and had not been made.

Q. Did you ever receive any type of explanation from anybody as to why that had not been paid?

A. Hell, no.

Q. Did you ask Baptist Medical Center [177] Montclair?

A. I sent them a little handwritten note because I don't have a secretary in Birmingham and asked them please fill out those forms and that is when I filed and that is when I got this response, these charges have previously been considered. If this is not a duplicate charge contact our customer service center. I never could get them to answer the phone out there. I tried time and again to call that number, it keeps ringing, ringing, ringing or it's busy.

Q. Did you ever talk to anyone verbally at Baptist Montclair about that?

A. No.

Q. And did you ever receive any written——

A. Wait a minute. I mentioned this to the Dr. Dick because on some occasions I would take Bedford out there and wait on her because often times he would do her at 5:00 when everybody else was gone and his head nurse, a loving woman, I can't remember her name, would stay there and I would take her home. On other occasions the housekeeper would take her and [178] wait while I had to work.

Q. Now, Judge, Exhibit 2-38 through 2-42——

A. Yeah.

Q. Were in your file attached to an envelope.

A. Well, I don't know whether they were attached to it, but there was an envelope there with them, and you see——

Q. The envelope is dated, has a post mark of December 7th, 1983?

A. Right.

Q. And let's mark the envelope as Exhibit 2-45. Did you ever write Mr. Rutledge on that date?

A. No, I just put them in this envelope and mailed them.

Q. So you just put these exhibits in the envelope?

A. Posted them to him.

Q. There is the post mark of December 7?

A. '83.

Q. And you didn't send him any [179] instructions with that?

A. No. He is a lawyer.

Q. Had you already employed Mr. Rutledge at that time?

MR. RUTLEDGE: Don't answer that question.

A. No.

MR. RUTLEDGE: Why do you want to know about our conversation? I didn't ask you about your conversations with your client.

MR. SIMPSON: I haven't filed a class action suit, either.

MR. RUTLEDGE: That doesn't entitle you to go into our conversation and relationship.

A. What Gene and I said to each other is not relevant to your complaint.

Q. Is that your personal judgment?

A. Personal.

MR. RUTLEDGE: Ask your next question and let me tell you that we are not going to answer questions which had to do with my relationship with my client, and I ask you as a matter of courtesy not to make those inquiries [180]

because I don't do it to you. How would you like it if I got Mr. Thrasher and said what did Mr. Simpson say to you before you took this deposition. I would resent that and out of courtesy to you I wouldn't ask it.

MR. SIMPSON: This is entirely different.

MR. RUTLEDGE: Name me one thing, one case or one authority that has to do with class action that gives you have the right to inquire into my relationship with my client.

MR. SOMERVILLE: Gene, there are cases.

MR. RUTLEDGE: Just name one, Bill. You and I have handled these things for years.

MR. SOMERVILLE: There are cases that say that the plaintiff's knowledge of participation in and the circumstances of a case, how he keeps up with it, what he does, what he knew about it before it was filed, all that is pertinent.

MR. RUTLEDGE: And you think this is necessary for—entitled him to know when he [181] retained me as an attorney? I instruct him not to answer the question.

A. And I shant.

Q. I will insist on an answer, but I will go on to another one in view of the witnesses reluctance.

A. Not reluctance. I'm just not going to answer it.

Q. Exhibit 2-45, does that refresh your recollection?

A. About what?

Q. About referring these claim summaries dated December 1st, 1983 on or before December 7th, 1983?

A. Sure, I must have gotten them before or I couldn't have mailed them to Gene on the 7th.

Q. I am not trying to trick you. You previously testified that you thought you have received them after Christmas?

A. No, I said before Christmas. You were talking about something earlier today.

MR. RUTLEDGE: He testified he got [182] them before Christmas because he wasn't in town Christmas.

A. I left Thursday before Christmas on Wednesday, whatever the dates were.

Q. I was asking you whether or not you had ever had any connversations with anybody at Baptist Montclair about it and you were telling me that you had?

A. I possibly mentioned it.

Q. To Dr. Dick?

A. About these bills, but, of course, well, I don't know anything about that. That is handled with some bookkeeping type folks. The doctors won't ever acknowledge they know anything about their charges except they want their damn money fast.

Q. What you are testifying to is that Dr. Dick's——

A. A paraphrase. I don't remember the exact words. The fellow has a Scottish brogue, but he is good.

Q. Is there anything else you can recall about your conversation with Dr. Dick about the [183] billing?

A. No, I mentioned that I understood they showed my account as being delinquent, past due and he said well, they filed those, they meaning bookkeeping end of his department, Baptist Medical, they file those claims, don't you worry about it. Well, hell, I didn't worry about it until that same group, the other arm, as it were, threatened to sue me and the notation, your insurance company has not paid. I don't know.

Q. Do you recall whether you have the subsequent statements after Exhibits 2-43 and 44?

A. If I had them they would be, I think pretty damn sure they were sent to Blue Cross as substantiating, what do you call it, supporting documents to the claim because those showed the dates that the——

MR. RUTLEDGE: Have those claims ever been paid?

A. I can't answer that directly, Gene, because I told you right after the lunch break how this all occurred.

[184] MR. RUTLEDGE: But I know—do you know whether or not they have ever been paid to date?

A. Yes.

MR. SOMERVILLE: What claims?

MR. RUTLEDGE: The ones on 2-38 through 2-41.

A. From time to time there were some more.

Q. Well, you have answered Mr. Rutledge that you do know whether they were or not?

A. Yeah.

Q. Were they?

A. Well, in a rather bazaar fashion.

Q. Can you tell me about that, please?

A. Yeah. When I filed this claim, these claims as a result of what were detailed about the therapeutic x-rays.

MR. RUTLEDGE: Give the exhibit number.

A. The statement that he has referred to on 2-43, 2-44 for the twenty-two hundred and fifty-nine dollars, let me try to [185] chronologically—when I kept getting these bills and I was assured don't worry about it, the claim has been filed by the group with Blue Cross, and yet I continued to get these bills, my best recollection is I sent these people checks, not for the twenty-two fifty-nine in total. I paid them over a period of sixty days. Meantime I got them to

complete the claim form and attached those itemized dates of therapy, x-ray therapy and put them with it and sent it to Blue Cross. Then I got this back and then later I started getting refund checks.

Q. By this you mean 2-38?

A. 2-38 through 2-42. Then I started getting refund checks in increments from the radiological group, much later. Now, what interpretation given, I don't know.

Q. Do you have—could you find your canceled checks for November or December or January?

MR. RUTLEDGE: If you will make an appropriate——

MR. SIMPSON: We have asked for that [186] in the notice of the deposition.

MR. RUTLEDGE: Let's see, which one do you have in mind?

MR. SIMPSON: Number one.

A. What does it say?

MR. RUTLEDGE: Any and all documents relating in any way to correspondence between the named plaintiff or his counsel.

MR. SIMPSON: I'm sorry, Gene, number four?

A. What does four say?

MR. RUTLEDGE: All medical records, reports, bills or other medical documents that relate in any way to the plaintiff or his wife, how would that include a check?

A. It doesn't.

Q. Well, do you have those? You would have, I think you said earlier you did have the canceled checks?

A. I have canceled checks.

Q. Well, can you give me your recollection? I'll make a request through counsel?

[187] A. I'm testifying from recollection, Simpson. I don't have a photographic memory.

Q. As to when you paid Baptist Montclair all or a portion of the amount represented?

A. I don't know. As I stated earlier, as I recall——

MR. RUTLEDGE: Let me state for the record that we'll attempt to identify and make available to counsel, Blue Cross the canceled checks and however——

A. I got boxes full of checks.

MR. RUTLEDGE: However, will require us to, I suppose sit down with Judge Embry and go through a number of checks. You haven't isolated them, have you, Judge?

A. No, hell, no.

MR. RUTLEDGE: But I do want to say that it's rather clear that whatever dates claims were filed with Blue Cross, when Blue Cross sent the checks is clearly within Blue Cross' knowledge, but as an effort to accomodate counsel we'll try to find those.

A. I'll bring them down here and y'all [188] sift through them.

Q. I don't want to belabor it but obviously a check from him to Baptist Montclair is not in our records.

MR. RUTLEDGE: In your records will be the dates that the claims were filed by those folks at Baptist Montclair, will be the dates that Justice Embry filed his claim on those items and also you will have the records of the date you sent the checks out to Baptist Montclair.

Q. Okay. Judge——

A. I'm handicapped because I don't have a secretary here and that is the reason you don't find copies of correspondence. These handwritten letters, I have been practicing law, I used to send things with cover letters, have a

record of it, but unfortunately I can't handle it that way without taking an undue amount of time.

Q. Well, Judge, what is your recollection?

A. What I have stated.

[189] Q. About——

A. I——

Q. Listen to my question.

A. Okay.

Q. What is your recollection about the date that you first received checks from Baptist Montclair as reimbursement for a check you paid them?

A. I have no idea.

Q. Do you recall how many checks you received from Baptist Montclair?

A. No. If there is a record of it——

MR. RUUTLEDGE: Judge, just a minute.

(Recess.)

Q. Judge, your counsel has called a recess to talk to you in the hall and comes back and says he thinks you may be able to help us. Can you help us?

A. I sure can.

MR. RUTLEDGE: Wait a minute, no. Counsel took Judge Embry out about two minutes in order to refresh his recollection on a matter that we hope will be of some benefit to Mr. [190] Simpson.

MR. SIMPSON: Thank you, Gene, I'm just recalling your outburst during Mr. Thrasher's deposition.

MR. RUTLEDGE: An unreciprocated courtesy.

MR. SIMPSON: I remember the statements in the record in Mr. Thrasher's deposition.

A. Do you want to repeat the question?

Q. I'll repeat the question.

A. As I recall the question was when did I refer the payments—that I received, you asked me when did I receive the reimbursement or refund from radiological group.

Q. I didn't say radiological group because this bill——

A. It says Baptist Montclair but that is what it was for, the 2-43. I got it, I started getting those from Baptist Montclair after this lawsuit was filed.

Q. So it would have been sometime after January of '84?

[191] A. Yeah, as I recall it was in the spring.

Q. Of '84?

A. Yeah, but I have some records.

Q. You do?

A. Yes.

Q. Could you bring those in the morning?

A. I'll bring them, but it's deposit slips and canceled checks.

Q. I was wondering if you might have a bottom part of the check, a voucher?

A. No, I don't keep those, but normally, except if it's twenty dollars or something, my procedure is to deposit these and show on the deposit slip income.

Q. Now, trying to wind up the controversy about Exhibit 2-43 and 2-44, are the amounts represented by those bills, did you receive eventually from Baptist Monclair the entire amount?

A. I don't know. They came in in increments so I deposited them.

Q. Well, do you have any knowledge of [192] when Baptist Montclair was paid by Blue Cross?

A. No, except what I deduced.

Q. Do you have any information as to when Baptist Montclair originally submitted claim to Blue Cross?

A. No idea. The only thing I can tell is on Exhibit 2-43 dated statement 8-18 statement date. Discharge date of the patient Bedford, 6-6-83 to date your insurance company has not paid on your account.

Q. And the follow-up on these exhibits, is it your judgment you submitted your claim to Blue Cross for these same charges shortly before December 1st, 1983?

A. Yeah. That Exhibit 2-38 through 2-42, no, 2-41 was the response I got from them that this has previously been considered, but no claim of mine had been previously considered, so it must have been what you call it, Baptist Montclair.

Q. It says this claim was previously considered, doesn't it?

A. Yeah.

[193] Q. Now, on the 2-42 is a claim summary that bears date November 17th, 1983 and apparently is unrelated to any type of extra controversy?

A. Dr. Howley's in-patient medical care. That was chemotherapy and his office lab stuff for having to do with blood count, this was the only occasion. Readmission in the hospital, which resulted in her death.

Q. And those were paid in due course and the percentages and amounts that were due?

A. I suppose.

MR. RUTLEDGE: But you don't know that, do you?

A. No, I don't know.

Q. But you have no information to the contrary, do you?

A. No.

Q. Do you want to stop, Judge?

A. I would like to.

MR. SIMPSON: Let's come back in the morning.

FURTHER DEPONENT SAITH NOT

[194] CERTIFICATE

STATE OF ALABAMA)

JEFFERSON COUNTY)

I hereby certify that the above and foregoing deposition was taken down by me in stenotypy, and the questions and answers thereto were reduced to typewriting under my supervision, and that the foregoing represents a true and correct transcript of the deposition given by said witness upon said hearing.

I further certify that I am neither of counsel nor of kin to the parties to the action, nor am I in any wise interested in the result of said cause.

/s/ KATHIE THAMES
Commissioner—Notary Public

Exhibit Five

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

ADDITIONAL SUPERSEDEAS BOND

WE the undersigned principal and surety, hereby bind ourselves to Margaret Lavoie and Roger J. Lavoie, Sr. in the amount of ONE MILLION SEVEN HUNDRED SIX THOUSAND EIGHT HUNDRED FORTY-EIGHT and 17/100 ($1,706,848.17) DOLLARS, for the payments of which we bind ourselves and each other, our heirs, executors, and administrators, jointly and severally, and as part of this undertaking we hereby waive our rights of exemption as to personal property under the Constitution and Laws of the State of Alabama.

WHEREAS, the above named Appellees, Margaret W. Lavoie and Roger J. Lavoie, Sr., recover a judgment against Appellants for the sum of ONE MILLION SEVEN HUNDRED SIX THOUSAND EIGHT HUNDRED FORTY-EIGHT and 17/100 ($1,706,848.17) DOLLARS.

Now, therefore, the condition of the foregoing obligation is such that, if the Appelant shall prosecute this appeal to effect and satisfy such judgment, penalties, costs, including costs of appeal as may be rendered in this case, then the said obligation to be null and void, otherwise to remain in full force and effect.

Executed with our seals this 8th day of March, 1985.

AETNA LIFE INSURANCE COMPANY
a Corporation

By: /s/ WILLIAM M. CUNNINGHAM, JR.

William M. Cunningham, Jr.
Its attorney
3763 Professional Parkway
Mobile, AL 36609

THE AETNA CASUALTY & SURETY COMPANY

/s/ D. E. LUDLOW
D. E. Ludlow
Attorney in Fact

AETNA [logo] LIFE & CASUALTY
THE AETNA CASUALTY AND SURETY COMPANY

Hartford, Connecticut 06115

POWER OF ATTORNEY AND CERTIFICATE OF AUTHORITY OF ATTORNEY(S)-IN-FACT

KNOW ALL MEN BY THESE PRESENTS, THAT THE AETNA CASUALTY AND SURETY COMPANY, a corporation duly organized under the laws of the State of Connecticut, and having its principal office in the City of Hartford, County of Hartford, State of Connecticut, hath made, constituted and appointed, and does by these presents make, constitute and appoint D. E. Ludlow, Nelda Loper or Betty Lane—of Mobile, Alabama, its true and lawful Attorney(s)-In-Fact, with full power and authority hereby conferred to sign, execute and acknowledge, at any place within the United States, or, if the following line be filled in, within the area there designated , the following Instrument(s): by his/her sole signature and act, any and all bonds, recognizances, contracts of Indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any and all consents incidents thereto

and to bind THE AETNA CASUALTY AND SURETY COMPANY, thereby as fully and to the same extent as if the same were signed by the duly authorized officers of THE AETNA CASUALTY AND SURETY COMPANY, and all the acts of said Attorney(s)-In-Fact, pursuant to the authority herein given, are hereby ratified and confirmed.

This appointment is made under and by authority of the following Standing Resolutions of said Company which Resolutions are now in full force and effect:

VOTED: That each of the following officers: Chairman, Vice Chairman, President, Any Executive Vice President, Any Senior Vice President, Any Vice President, Any Assistant Vice President, Any Secretary, Any Assistant Secretary, may from time to time appoint Resident Vice Presidents, Resident Assistant Secretaries, Attorneys-in-Fact, and Agents to act for and on behalf of the Company and may give any such appointee such authority as his certificate of authority may prescribe to sign with the Company's name and seal with the Company's seal bonds, recognizances, contracts of Indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any of said officers or the Board of Directors may at any time remove any such appointee and revoke the power and authority given him.

VOTED: That any bond, recognizance, contract of Indemnity, or writing obligatory in the nature of a bond, recognizances, or conditional undertaking shall be valid and binding upon the Company when (a) signed by the Chairman, the Vice Chairman, the President, an Executive Vice President, a Senior Vice President, a Vice President, an Assistant Vice President or by a Resident Vice President, pursuant to the power prescribed in the certificate of authority of such Resident Vice President, and duly attested and sealed with the Company's seal by a Secretary or Assistant Secretary or by a Resident Assistant Secretary, pursuant to the power prescribed in the certificate of authority of such Resident Assistant Secretary; or (b) duly executed (under seal, if required) by one or more Attorneys-in-Fact pursuant to the power prescribed in his or their certificate or certificates of authority.

This Power of Attorney and Certificate of Authority is signed and sealed by facsimile under and by authority of the following Standing Resolution voted by the Board of Directors of THE AETNA CASUALTY AND SURETY

COMPANY which Resolution is now in full force and effect:

VOTED: That the signature of each of the following officers: Chairman, Vice Chairman, President, Any Executive Vice President, Any Senior Vice President, Any Vice President, Any Assistant Vice President, Any Secretary, Any Assistant Secretary, and the seal of the Company may be affixed by facsimile to any power of attorney or to any certificate relating thereto appointing Resident Vice Presidents, Resident Assistant Secretaries or Attorneys-in-Fact for purposes only of executing and attesting bonds and undertakings and other writings obligatory in the nature thereof, and any such power of attorney or certificate bearing such facsimile signature or facsimile seal shall be valid and binding upon the Company and any such power so executed and certified by such facsimile signature and facsimile seal shall be valid and binding upon the Company in the future with respect to any bond or underwriting to which it is attached.

IN WITNESS WHEREOF, THE AETNA CASUALTY AND SURETY COMPANY has caused this instrument to be signed by its Assistant Vice President, and its corporate seal to be hereto affixed this 16th day of July, 1981

THE AETNA CASUALTY AND SURETY COMPANY

[AETNA SEAL]

By /s/ R. T. RIPPE

Assistant Vice President

State of Connecticut)
) ss. Hartford
County of Hartford)

On this 16th day of July, 1981, before me personally came R. T. Rippe, to me known, who, being by me duly sworn, did depose and say: that he/she is Assistant Vice President of THE AETNA CASUALTY AND SURETY COMPANY, the corporation described in and which executed

the above instrument; that he/she knows the seal of said corporation; that the seal affixed to the said instrument is such corporate seal; and that he/she executed the said instrument on behalf of the corporation by authority of his/her office under the Standing Resolutions thereof.

/s/ JOHANNA M. DEGNAN

Notary Public

[NOTARY SEAL]

My commission expires
March 31, 1984

CERTIFICATE

I, the undersigned, Secretary of THE AETNA CASUALTY AND SURETY COMPANY, a stock corporation of the State of Connecticut, DO HEREBY CERTIFY that the foregoing and attached Power of Attorney and Certificate of Authority remains in full force and has not been revoked; and furthermore, that the Standing Resolutions of the Board of Directors, as set forth in the Certificate of Authority, are now in force.

Signed and Sealed at the Home Office of the Company, in the City of Hartford, State of Connecticut. Dated this 8th day of March, 1985

By /s/ VINCENT A. WALL
Secretary

[AETNA SEAL]

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

SECOND APPLICATION FOR REHEARING

COMES now the Appellant, AETNA LIFE INSURANCE COMPANY, through its undersigned counsel, and hereby applies for a second rehearing on the judgment of this court entered on December 7, 1984 and as grounds for said application would adopt the original Application For Rehearing, with amendment, and its Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984 and for Hearing De Novo, with amendment and further would set forth the following additional grounds:

1. Justice Embry's deposition was given on January 10, 1985 in the Circuit Court of Jefferson County, *T. Eric Embry v. Blue Cross/Blue Shield of Alabama,* Civil Action No. CV-84-500-447 and in his testimony admitted that he was the author of the Opinion of December 7, 1984 and that he had written on the Opinion for the first eight or nine months of 1984, which would have been prior to oral argument held on May 14, 1984. Further, his testimony refers to insurance companies in general and reflects a bias and prejudice against them. (See deposition pages 35, 36 and 38 in exhibit 5 to Motion to Suspend Rules and For Stay of Execution of Judgment)

2. On March 20, 1985, the appellant, through its attorneys, became aware of the contents of Justice Embry's deposition. (See affidavits attached as Exhibits "1" and "2" to the Motion to Suspend Rules and For Stay of Execution of Judgment)

3. The appellant attaches hereto a brief in support of this Second Application for Rehearing and further adopts its Brief filed in support of the original Application For Rehearing and the Brief filed in Support of its Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984 and for Hearing De Novo.

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, Alabama 36609

By: /s/ PETER V. SINTZ
Peter V. Sintz

By: /s/ WILLIAM M. CUNNINGHAM, JR.
William M. Cunningham, Jr.

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

BRIEF IN SUPPORT OF APPELLANT'S SECOND APPLICATION FOR REHEARING

In denying Appellant's Motions on March 8, 1985, each Justice of this Court passed judgment on his or her qualifications to have participated in the consideration and decision of this case, Appellants' Application for Rehearing, and Appellant's Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984 and for hearing De Novo ("February 21, 1985 Motions"), by implicitly refusing to pass judgment on the qualification of the Honorable T. Eric Embry, this Court necessarily refused to decide Appellant's clear, unequivocal Federal Constitutional challenge to the participation of Justice Embry in the consideration and decision of this case and the February 21, 1985 Motions.

Contrary to the Opinion of Justice Maddox concurring specially as to the ruling of this Court on Appellant's Motion for Disqualification, Justice Embry's disqualification under the Provisions of the Alabama Canons of Judicial Ethics was *not* the "primary thrust" of Appellant's February 21, 1985 Motions. Although Appellant believes that Justice Embry was and is disqualified under those Canons, Appellant's primary contention in its February 21, 1985 Motions, the substance of which is renewed by Appellant before this Court today, is that Justice Embry is disqualified by the Due Process Clause of the Fourteenth Amendment of the Federal Constitution from having participated in the consideration and decision of this case

and all related Motions, including the Application for Rehearing, and that Appellant's Federal Constitutional right to a fair hearing of its case can be vindicated only by the disqualification of Justice Embry, withdrawal of this Court's per curiam Opinion of December 7, 1984 which was in fact authored by Justice Embry, and appointment by the Governor of Alabama of a temporary court to hear, consider and decide Appellant's case *de novo,* all of whose members are qualified to hear and decide Appellant's case De Novo, including all issues in its case raised by Appellant to the present date. In re: *Murchison,* 349 U.S. 133, 136 (1955). Appellant's argument that these remedies are necessary to vindicate its Constitutional rights are not dependent in any way on Justice Embry's continued prosecution through his counsel of his civil action in the Circuit Court of Jefferson County. The proceedings in this case to date are Constitutionally tainted, and that taint can only be removed by withdrawal of the Opinion and a full hearing *de novo* as set forth above.

Appellant's position is that this Court has an institutional duty to decide Appellant's Federal Constitutional challenge set forth in Appellant's February 21, 1985 Motions and renewed in this Court today. Appellant believes itself to be obligated at this point in these extraordinary proceedings to make clear that any action of this Court which does not grant Appellant full vindication of its Federal Constitutional rights will be appealed to the Supreme Court of the United States.

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, Alabama 36609

Original Signed By:

By: Peter V. Sintz
PETER V. SINTZ

Original Signed By:

By: William M. Cunningham, Jr.
WILLIAM M. CUNNINGHAM, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have this 22nd day of March, 1985, served a copy of the above and foregoing pleading upon Joseph M. Brown, Jr., attorney for appellees, by hand delivering same and to all other parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

Original Signed By:

William M. Cunningham, Jr.

WILLIAM M. CUNNINGHAM, JR.

Honorable Joseph M. Brown, Jr.
Attorney at Law
1601 Dauphin Street
Mobile, AL 36660

Honorable Charles A. Graddick
Attorney General
250 Administrative Building
Montgomery, AL 36130

Honorable Edgar M. Elliott, III
Attorney at Law
1700 Financial Center
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Honorable James T. Upchurch
Attorney at Law
Post Office Box 270
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Honorable Thad Salmon
Attorney at Law
2108 East South Boulevard
Montgomery, AL 36111

Honorable Lanny Vines
Attorney at Law
1800 City Federal Bldg.
Birmingham, AL 35203

Honorable Harry Cole
Attorney at Law
Post Office Box 116
Montgomery, AL 36195

IN THE SUPREME COURT OF ALABAMA

Supreme Court No.: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

- VS -

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*

AMENDMENT TO MOTION TO SUSPEND RULES AND MOTION FOR STAY OF EXECUTION OF JUDGMENT

COMES now the appellant, AETNA LIFE INSURANCE COMPANY, through its undersigned counsel, and amends it Motion to Suspend Rules and Motion for Stay of Execution of Judgment by attaching the affidavit of George R. Heitz.

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, Alabama 36609

Original Signed By:

By: Peter V. Sintz
Peter V. Sintz

Original Signed By:

By: William M. Cunningham, Jr.
William M. Cunningham, Jr.

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant*,

-vs-

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees*.

AFFIDAVIT OF GEORGE R. HEITZ

STATE OF CONNECTICUT
COUNTY OF HARTFORD

Personally appeared before me, the undersigned authority in said State and County, GEORGE R. HEITZ, who is known to me and who after being duly sworn, deposes and says as follows:

My name is GEORGE R. HEITZ and I am over the age of twenty-one years. I am employed by the Aetna Life Insurance Company of Hartford, Connecticut. My position is that of Legal Officer and in that capacity I am knowledgeable of the Margaret Lavoie vs. Aetna Life Insurance Company lawsuit.

My first notice of the substance of Justice T. Eric Embry's testimony given in his deposition of January 10, 1985, was when I received and read a copy of the deposition on March 21, 1985. Prior to that date, I had been advised by one of the attorneys with the firm of Sintz, Pike, Campbell & Duke that Justice Embry had mentioned the *Lavoie* case in his deposition. Until I was able to read the deposition I was not aware of the substance of his testimony.

/s/ GEORGE HEITZ

George Heitz

Subscribed and sworn to before me on this 21st day of March, 1985.

/s/ illegible signature

CERTIFICATE OF SERVICE

I hereby certify that I have this 22nd day of March, 1985, served a copy of the above and foregoing pleading upon Joseph M. Brown, Jr., attorney for appellees, by hand delivering same and to all other parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

By: /s/ WILLIAM M. CUNNINGHAM, JR.
William M. Cunningham, Jr.

Honorable Joseph M. Brown, Jr.
Attorney at Law
1601 Dauphin Street
Mobile, AL 36660

Honorable Charles A. Graddick
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Honorable Harry Cole
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Post Office Box 116
Montgomery, AL 36195

APPENDIX H

IN THE SUPREME COURT OF ALABAMA

Supreme Court No: 82-426

AETNA LIFE INSURANCE COMPANY, *Appellant,*

-vs-

MARGARET W. LAVOIE and ROGER LAVOIE, *Appellees.*
[Filed Mar 25 1985 Supreme Court of Alabama]

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Aetna Life Insurance Company, the appellant abovenamed, hereby appeals to the Supreme Court of the United States from:

(a) The final judgment of the Supreme Court of the State of Alabama of December 7, 1984, affirming the judgment of the Circuit Court of Mobile County against appellant entered in this action on November 4, 1982;

(b) The final order issued by the Supreme Court of Alabama, denying appellant's Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984, and for Hearing De Novo, and overruling the Application for Rehearing entered on March 8, 1985.

(c) The final order issued by the Supreme Court of Alabama, denying appellant's Motion to Suspend Rules and Motion for Stay of Execution of Judgment, entered on March 25, 1985.

This appeal is taken pursuant to 28. U.S.C. § 1257(2).

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, Alabama 36609

By: /s/ PETER V. SINTZ
Peter V. Sintz

By: /s/ WILLIAM M. CUNNINGHAM, JR.
William M. Cunningham, Jr.

CERTIFICATE OF SERVICE

I hereby certify that I have this 25th day of March, 1985, served a copy of the above and foregoing pleading upon counsel for all parties to this proceeding by placing a copy of same in the United States mail, First Class postage prepaid.

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APPENDIX I

THE STATE OF ALABAMA — — — — JUDICIAL DEPARTMENT

THE SUPREME COURT OF ALABAMA
October Term, 1984-85

82-536 & 82-917

Nationwide Mutual Insurance Co.

v.

Henry Gerrard Clay

APPEALS FROM MOBILE CIRCUIT COURT

[Filed Feb 8 1985 Clerk Supreme Court of Alabama]

ALMON, JUSTICE.

These consolidated appeals involve a claim for bad faith failure to pay a claim on a disability insurance policy. At trial, the court granted a directed verdict for the plaintiff insured in the amount of $46,165.00 on the contract count. The jury returned a verdict for the plaintiff in the amount of $1,250,000.00 on the bad faith count. The trial court denied the defendant insurance company's post-trial motions, and the company appeals.

FACTS

Because the issues turn on fact questions, we include the following detailed statement of facts. The facts are supported largely by the numerous exhibits, including memoranda of conversations from Nationwide's file on Clay's claim. Clay also kept notes of his telephone conversations and while testifying used them to refresh his memory.

Henry Gerrard Clay applied for a policy of disability insurance with Nationwide Mutual Insurance Company on December 8, 1976. Clay was a practicing attorney in Mobile, and he applied for this policy at the instigation of his friend Bill McDowell, who had previously sold him a hospitalization insurance policy with Nationwide. McDowell filled out the application as Clay gave him the information required.

Two answers on the application later gave rise to charges by Nationwide of misrepresentation: To the question, "What is your average earned monthly income?" Clay answered, "$1,800." To the question, "Will the insurance applied for replace existing Disability Income Insurance . . . owned by applicant?" Clay answered, "Yes," and stated the company and amount as "Paul Revere $400/month."

Clay went to the office of Dr. Herbert Allen on December 14, 1976, for a physical examination. Clay testified that he did not remember seeing the doctor, but thought he had only seen a nurse, who took a blood sample and some measurements. The report indicates Clay was having no problems with his eyes. Clay's disability giving rise to the instant lawsuit was cataracts, which were diagnosed on August 29, 1977.

Nationwide issued the disability income policy effective January 19, 1977, but because McDowell told the underwriting department that Clay should be rated a Class AAA risk instead of a Class A risk, the policy was not sent to Clay until this change was made and did not reach him until March.

In the meantime, Clay had called Paul Revere Insurance Company to cancel the disability policy he had with that company. A Paul Revere agent, Leon Adams, called on Clay to ask why he had cancelled his policy. Clay told Adams that he intended to buy a disability policy with

Nationwide. Adams compared the Paul Revere contract with the Nationwide contract and offered Clay increased coverage with Paul Revere. As Adams testified, "I talked him into getting a lot more coverage." On February 4, 1977, Clay applied for disability insurance with Paul Revere in the amount of $2200 per month and a policy was issued on February 26. When he received the Nationwide policy in March, he tried to cancel it, but could not reach McDowell, who had been promoted. Clay allowed both policies to remain in effect, with premiums being paid on a monthly bank draft.

On April 29, 1977, Clay visited Dr. Charles Ivey Williamson for a checkup, complaining that he had had fever recently and was feeling tired and run down. Dr. Williamson conducted lab tests, which showed a possibility of a viral infection affecting Clay's liver, but nothing seriously abnormal. Dr. Williamson recommended a diet and rest. His records indicated that Clay did not complain to him at this time of eye problems.

Clay continued to run a fever and feel sick through the spring and summer. On August 29, he went to Dr. Edwin A. Ross, his optometrist, with whom he had regular checkups. Dr. Ross diagnosed cataracts, which had caused his vision to drop from 20/20 in each eye to 20/40 in the left eye and 20/50 in the right. Dr. Ross testified that Clay's cataracts were in such a position that they caused a severe loss of vision and could not be corrected with glasses. He also testified that the cataracts developed in a short period of time, unlike in older people [1] where they cause a gradual loss of vision. Dr. Ross recommended that Clay see an ophthalmologist. On September 7, 1977, Clay saw Dr. James M. Harrison, who confirmed that Clay had cataracts.

Clay closed his law office, referred his clients with active files to other attorneys, and stored his books, office equip-

[1] Clay was 38 when his cataracts developed.

ment, and other items in a warehouse. On September 26, 1977, Clay filled out a disability claim to file with Nationwide. He stated that the symptoms first appeared "July, 1977 to August, 1977." Clay left blank the spaces on the form for "Monthly income" and "any other Companies with whom you may carry Accident & Sickness insurance." Dr. Harrison completed the attending physician's portion of the form, indicating that Clay was totally disabled from September 7, 1977, "until recovered from surgery," and that the symptoms appeared "gradually."

Nationwide received the claim form at its group claims office in Atlanta on October 3. That office forwarded the form to Nationwide's office in Columbus, Ohio, where it arrived on October 13, 1977. The claim was assigned to Jim Otey, a medical claims examiner, on October 20. On November 10, Clay called to inquire about the status of his claim and requested a reply by telephone. On November 11, he called again. The message in Nationwide's file on Clay's claim includes the notation, "Please Call Today." Nationwide did not return either call.

Clay telephoned twice on November 14, and talked to Otey. Clay testified that when he first called, Otey refused to find his file, saying, in Clay's words, "if he started doing it for me he would have to talk to anybody that had a claim anytime they wanted to talk to him." Otey denied that he ever refused to look for Clay's file. Clay testified that during this first conversation Otey told him he had seen the file, whereupon Clay asked if Nationwide was going to pay. Clay testified that Otey answered,

> " 'Naw, no decision's been made on it yet.' He said, 'but I,' he said, 'I can tell you right now' and he said, 'cataracts are not a disability. They take at least two years to become disabling.' And he said, his exact words, he said, 'there's no way I could be disabled with cataracts.' "

Clay called Otey again on the afternoon of November 14, at which time Clay mentioned to Otey that Dr. Ross had first diagnosed his cataracts. Otey responded that Dr. Ross, instead of Dr. Harrison, would have to file the attending physician's report. Someone at Nationwide had initially told Clay that he should have Dr. Harrison fill out the claim form because Dr. Harrison was a medical doctor and Dr. Ross was not. Otey told Clay that the doctor who originally discovered the cataracts would have to send a statement.

Otey examined the file in detail on November 15. He was concerned whether Clay's cataracts existed prior to the policy coverage, although he had seen the report from Dr. Allen showing Clay had no eye problems on December 14, 1976. Otey had Equifax Services arrange for another doctor to examine Clay. Dr. Dan Rencher, an ophthalmologist, examined Clay on November 21, and sent a report to Equifax on November 23. Dr. Ross also sent a form to Nationwide on November 23 giving his diagnosis of cataracts.

Dr. Rencher's report stated:

> "In my professional opinion there is in Mr. Clay's case the presence of some disability in that he is an attorney at law which necessitates that he read a considerable amount and he is experiencing difficulty doing so. It is my opinion that this disability is due solely to the cataracts."

Dr. Ross's report included the following:

(2A) When did symptoms first appear or accident happen?
Date: Prior to Aug 29, 1977

(B) When did patient first consult you for this condition?
Date: Aug 29, 1977

(C) Has patient ever had same or similar condition?
If "Yes" state when and describe
Yes ☐ No ☒

Neither of these reports clarified whether Clay's cataracts developed prior to the effective date of the coverage. Nationwide received Dr. Ross's report on December 1, 1977, but did not receive Dr. Rencher's report from Equifax until December 16. Otey denied to Clay that Dr. Rencher's report had been received, and later Equifax obtained another report, which stated that in Dr. Rencher's opinion Clay's "visual acuity constitutes a disability in his work as an attorney at law." Nationwide received this copy on January 4, 1978.

Other activity concerning Clay's file continued while these doctors' reports were proceeding. Bill McDowell, who had transferred to Nationwide's office in Birmingham since selling Clay his policy, testified that he saw Clay around Thanksgiving and that at that time Clay's vision was poor and he was keeping the house dark. McDowell talked to Otey on the telephone on November 30, 1977, and said Clay thought Nationwide was "trying to pull something." Otey denied at trial that McDowell had relayed this message, but his notes on the conversation mention it, including the 'anguage just quoted. The notes also state that Otey *"assured"* (Otey's emphasis) McDowell "we had not even thought in that way. Just routine handling as all cataracts were contestable. Exam was 11/21 and we should be getting report soon." Otey's notes conclude with an indication that McDowell responded "OK—carry on."

Clay talked to McDowell on December 2. He testified that McDowell said Otey would pay only when Clay set a date for an operation. Clay then telephoned Otey, who denied that he was waiting for an operation date and said that he was waiting for the report from Dr. Rencher.

Clay said he would call Dr. Rencher to help speed up the report.

Clay telephoned McDowell again on December 5, at which time, as he testified, McDowell told him Otey thought he was working and concealing income and had "made his own disability." When Clay called Otey to ask what he meant, Otey would not discuss it. Clay asked to talk to Otey's superior, but Otey said there was no one else he could talk to except in the legal department.

Clay talked to Otey and McDowell several more times, including once on December 21, when Otey stated that he was still waiting for Dr. Rencher's report, but would not go get the file. As noted above, Nationwide stamped Dr. Rencher's report "received" on December 16. Otey testified that Equifax, in forwarding the report, had not included the claim number, so placing it in the proper file took longer. Clay told Otey that Nationwide had selected Dr. Rencher, Clay had kept his appointment, Dr. Rencher had sent the report a month earlier, and Nationwide was making no effort to investigate.

Clay also complained that Nationwide was still deducting premiums from his checking account even though the policy had a waiver of premiums provision. Otey responded that the premiums would have to continue until he was satisfied of total disability and that company policy was that any premiums that should have been waived would be refunded later.

During this December 21 conversation, Clay continued to request that Otey get the file. Otey suggested that if Clay could give him the claim number, he might be able to retrieve the file. Clay sorted through his papers and, using a magnifying glass, read the claim number to Otey. Clay testified that Otey responded, "well, that proves you can read and we don't owe you any disability," and accused him of concealing income.

Otey also asked Clay if he had any other insurance. Clay's testimony about this exchange includes the following:

> "I said, 'listen you have had this claim here for three months to do it,' and I said, 'listed on the application is a Paul Revere policy.' I said, 'have you even called them or telephoned 'em or written any letters to find out about that Paul Revere policy?' He said, 'no, I'm talking about other policies. Something where you're concealing from us.' I said, 'well, the only thing—' I said, 'I've got a little thing, insurance thing that I sent for the mortgage payments on my house.' . . .
>
> ". . . And he said, 'I know about that.' His exact words says, 'I know about Paul Revere and the mortgage insurance with American Home.' He said, 'do you mean to tell me you have no other disability insurance other than Paul Revere and American Home Mortgage Insurance?' I said, 'that's right. I have no other insurance other than that; no other disability income insurance.'
>
> "Q Did you have any other, please, sir?
>
> "A No. No other disability income insurance. But I knew in the back of my mind that he didn't understand, that he was being a little bit misled but he was misleading himself. This is—Three months had gone by and he hadn't even looked at the file other than to make accusations on the telephone."

On December 30, Clay called Otey, who said the claim had been turned over to the legal department. Around this time, Otey took the file to John Harker, claims attorney for Nationwide. On January 13, 1978, Harker and Otey requested Nationwide's in-house doctor to review Clay's doctors' reports—the file now included Dr. Harrison's report, Dr. Ross's report, and the two reports from Dr.

Rencher—and answer the question, "Noting the degree of sight he has in each eye, would an individual of this occupation be totally disabled?" The doctor returned the form on the same day with the notation, "Not completely and totally unable to perform his usual and customary occupation." Otey mentioned to Harker the probability of other insurance being involved. He testified that taking the claim to Harker effectively terminated his active involvement in handling the file.

On January 11, 1978, O. B. Carr, an insurance investigator with the Alabama Department of Insurance, sent a letter to Nationwide, which reads: "Please advise this department relative to disposition of referenced claim. Mr. Clay alleges to have been continuously totally disabled since September 7, 1977." Nationwide received this letter on January 16.

Also on January 16, Harker wrote Clay stating that Nationwide would not pay the claim. Harker testified that he disagreed with the in-house doctor's conclusion and believed Clay was totally disabled from practicing law. He based the denial of coverage on his conclusion that Clay's cataracts pre-existed the effective date of coverage. Harker's letter stated that Dr. Ross's report "indicates that although he did not treat you until August 29, 1977, symptoms of your condition began prior to 1977." (See the portion of Dr. Ross's report duplicated above.) The letter concluded with a statement that Nationwide would be "more than happy to review" any additional information from Clay and reconsider the claim.

Clay telephoned Harker on January 11, 17, and 18, but was told Harker was not in. He reached Harker on the morning of January 19th before receiving his mail. Harker told him of the letter tentatively denying coverage due to pre-existence of cataract symptoms. After Clay received the letter in the mail later that day, he called Harker back and accused him of intentionally misreading Dr. Ross's

report. Harker told Clay he would immediately send a payment for one month's benefits and approve payment on the claim as soon as Dr. Ross confirmed that Clay did not have cataracts prior to 1977. Clay testified that he did not receive this first check until February 13.

In his notes on the conversation, Harker included a note to have Equifax inquire whether Clay had any other policies. In conducting an investigaton, Equifax learned that Clay had not filed income tax returns for 1975, 1976, or 1977. Nationwide also learned that Clay had a $2200 Paul Revere policy that was a "make over" of the policy mentioned on Clay's application with Nationwide. Clay testified that he talked to Harker on January 31, 1978, and Harker said that if the Paul Revere policy was issued after the Nationwide policy, it wouldn't affect Clay's coverage with Nationwide, but that "they [Nationwide] would pay full coverage." Harker later received a letter from Paul Revere stating that their policy was a "new policy" issued in February 1977 as a make-over of his 1966 policy. When he talked to Clay on February 20, he said, according to Clay, that the Nationwide policy had been issued first. Based on this information, Clay agreed with Paul Revere to reduce his coverage from $2200 per month to $1250 per month with a one-year additional benefit of $150 per month.

During this period, the question of the onset of Clay's disability was settled to Harker's satisfaction. He did not talk to Dr. Ross the day after the January 19 conversation with Clay, but wrote a letter to Dr. Ross on February 7 asking for the date the cataracts appeared. Dr. Ross replied that there had been nothing abnormal when he had examined Clay on November 3, 1976, and no sign of "any significant impairment of visual acuity—until the exam of August 29, 1977." Harker had instructed Otey to request "continuation of disability" statements from Clay and Dr. Ross and include these forms with the check authorized on

January 19, which Clay received on February 13. When Harker received the letter from Dr. Ross on February 23, he sent it to Otey with instructions to pay Clay's sickness disability income. Otey noticed that the "continuation of disability" forms were not in the file, initialed Dr. Ross's letter with a notation "Forms out," and held up the benefits.

On February 28, Nationwide received another letter from O. B. Carr of the Alabama Department of Insurance, referring to the unanswered January 11 letter and requesting Nationwide to advise the department as to the present status of Clay's claim. Harker responded on March 7, stating that he was unable to determine if Nationwide had received the first letter. He recited the history of Clay's application, claim, and the treatment thereof. The letter concluded, "At this time, we are awaiting only return of claim forms from Mr. Clay indicating disability and dates of treatment through the present. Immediately upon receipt of that information, we will be in a position to bring Mr. Clay's disability payments up to date."

When Clay received a copy of this letter on March 9, he called Harker and said there was a lot in the letter that was not true, particularly the statement that Nationwide was merely awaiting forms from Clay. Clay testified that the forms were not inclosed with the check. He said he complained to Harker, "[I]t's been one series of promises after another and you've never said anything about waiting on anything from me . . . . [E]very time that you say you'll pay as soon as you get a medical report you don't pay." Clay threatened to have the insurance department investigate or to sue, whereupon Harker said, according to Clay, "[I]f you file suit, you won't get a nickel for at least ten years."

Harker offered to send another one-month "good faith" payment of $1300, and Clay responded, "[A]bsolutely not . . . either pay it up or deny the claim." Harker agreed

to pay the benefits current to February 1, and Clay agreed to return a current medical report if Harker sent him a form along with the payment. Harker's notes on this conversation read:

> "Pay another payment to Feb. 1, 1978. He will send forms. I don't believe we can justify a delay since his condition could not improve without surgery. Also suggest we send Equifax now to investigate if office is open."

An Equifax agent asked Clay on March 15 to release his income tax returns, which Clay refused to do. The agent called Otey to tell him this, and that Clay apparently had not filed a return for 1976. Also on March 15, Dr. Ross completed the continuation of disability forms and sent them to Nationwide. They were received on March 21.

On March 28, Harker wrote Clay:

> "In investigating a claim which you have against the above indicated policy, it has come to our attention that there may be certain information which was withheld from us on the application; information which was necessary in determining the amount of disability insurance for which you would have been eligible under our company rules.
>
> "Based on that fact, I find that we will need some proof of the income which you represented on your application in December, 1976. That is, at that time, you indicated you were averaging $1,800 per month. Information has come to our attention that you were making far less than that and as such, we will need proof of income.
>
> "Although, as I am sure you are aware, you have no duty to provide us with income tax records[, a] copy of your tax return would effectively close the matter. Any other information you can provide showing income would be quite beneficial."

Harker testified that if Clay had not filed income tax returns, "there was a strong possibility in my mind that he had had no income. . . . If his income was less, it would have affected the policy as well based on the other insurance that he had."

Clay testified that when he received this letter he called Harker and told him:

> "I thought the only reason he'd asked for that is because Bill McDowell had told him I didn't have tax returns but that I did have . . . that I kept good records in my office and I said it'd be fairly easy for me to verify my income for 1976 but . . . I did not believe him when he said it would close the matter. . . . I said, if there's anything that's come to your attention that's new and you have a reason to ask for the tax return, . . . I will try to verify my income during 1976 just like you said. But, I said, without that, . . . it's unreasonable for you to ask for it at this point; you've had six months to investigate it."

His testimony continued:

> "Q What did he say, please?
>
> "A Well he said that the company had discussed it and that was the position they were gonna take . . . [b]ut he said he didn't think that he had to tell me the details of his investigation. So he wouldn't tell me why he wanted the income tax return."

On April 5, O. B. Carr again wrote Harker, stating that "Obviously, Mr. Clay is concerned over your change of plan." Harker wrote back, asking Carr to help Nationwide to persuade Clay to submit his income tax returns. Clay filed this suit on July 14, 1978.

PROCEEDINGS BELOW

Clay's originial complaint, filed on July 14, 1978, sought damages in the amount of $100,000 for breach of contract. Nationwide answered with a general denial of the allegations of breach, stating that "at this time it has still not completed its investigation." Nationwide included with its answer a request for production of Clay's federal and state income tax returns and his hospital, doctor, and medical reports. When Clay did not respond, Nationwide filed a motion for the court to compel Clay to produce the documents. The court granted this motion on February 8, 1979, giving Clay 20 days to comply. When he did not, Nationwide filed on March 6 a motion styled "Motion for Default Judgment," which we take to be a motion to dismiss pursuant to Rule 37(b)(2)(C), A. R. Civ. P.

In response to this motion, Clay stated that he had not filed income tax returns for the years in question. He gave a deposition concerning these matters on May 30, 1979. The case was continued several times, and in March 1980, Clay's original counsel withdrew and his present counsel entered an appearance. The parties conducted further discovery and the court granted continuances until, on April 29, 1981, Clay filed his first amended complaint.

The amended complaint included three counts: one for bad faith "in failing and refusing to pay the plaintiff the benefits due under such policy and in continuing to require and accepting premiums for said policy;" a second count for fraud; and a third count for breach of contract. The first two counts each sought $1,500,000 in damages, and the third sought $150,000. This amendment came shortly after this Court recognized a cause of action against insurers for bad faith failure to pay a claim in *Chavers v. National Security Fire & Cas. Co.*, 405 So. 2d 1 (Ala. 1981).

Nationwide sought discovery from Clay of documentation of Clay's income for 1970 through 1980. On May 8,

1981, Nationwide filed a motion to compel Clay to respond to these discovery requests. On January 28, 1982, Clay filed a motion to limit discovery. The court on February 5 granted the motion "to the extent that the Plaintiff shall at this time produce to the Defendant the amount of deposits to his attorney accounts during the period in question." Clay supplied a listing of deposits for the years 1969 through 1976. Approximately two weeks before trial, Clay provided records of his bank deposits for January through September of 1977.

On February 22, 1982, Clay filed a second amended complaint, which corrected some of the factual allegations. Nationwide filed an answer to this amended complaint (it had not answered the first amended complaint), denying that it had acted in bad faith and stating that it received information in March 1978 which prevented the previously anticipated resolution of the claim. Clay filed a third amended complaint on April 23, 1982, amending the *ad damnum* clauses of each count to claim $3,000,000.

Nationwide's answer to the third amended complaint added defenses that Clay's earnings were insufficient to provide the benefits provided in the policy; that any benefits due were to be prorated with Clay's other disability income policies; that Clay had misrepresented his income in obtaining the policy; that, to obtain the Nationwide policy, Clay had represented he would cancel the Paul Revere policy, but instead had increased it; that Nationwide had breached no duty of good faith; and that Nationwide had a lawful basis for ceasing to make payments. Clay points out that Nationwide also denied having demanded premium payments and added as a defense that Clay "failed to mitigate his claim by undergoing corrective surgery within a reasonable period of time after becoming disabled." Nationwide withdrew this defense on the morning of trial.

The case went to trial on December 13, 1982, and the trial lasted through December 17. The trial court denied motions by Nationwide for directed verdict at the close of Clay's evidence and at the close of all the evidence. At the close of all the evidence, the trial court granted Clay's motion for directed verdict on the contract count and denied it on the bad faith count. The court granted a directed verdict for Nationwide on the fraud count. On the contract claim, the trial court awarded $46,165.00. The jury returned a verdict of $1,250,000.00 on the bad faith claim. The trial court later denied Nationwide's motion for judgment notwithstanding the verdict, new trial, or remittitur. Nationwide appealed.

ISSUES

Nationwide states eleven issues, but argues them under the following four headings: 1) The trial court erred in directing a verdict for Clay under the contract claim; 2) The trial court erred in denying Nationwide's motions for directed verdict on the bad faith claim; 3) Various rulings by the trial court improperly and materially prejudiced the defendant; and 4) The trial court erred in refusing to order a remittitur. We shall discuss the issues under corresponding hearings.

THE CONTRACT CLAIM

Nationwide argues that the court should not have directed a verdict for Clay because there was evidence in favor of Nationwide's position that it was not liable on the contract claim. Nationwide asserts that there was substantial evidence that Clay misrepresented his income and falsely stated that he would cancel the Paul Revere policy. According to Nationwide, each of these misrepresentations provided a basis upon which to void the policy. Nationwide further argues that the dispute as to the amount due on the policy makes the directed verdict improper.

Regarding Clay's statement on the application that his income was $1800 per month, Nationwide's primary argument is that, although Clay's deposits to his law office account for 1976 totalled $26,714.41, his office overhead averaged $900 to $1000 per month and thus his income was less than $1800 per month. Nationwide argues that it does not have to prove that Clay intentionally misstated his income, because Code 1975, § 27-14-7, provides that

> "Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:
>
> (1) Fraudulent;
>
> (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
>
> (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued a policy or contract at the premium rate as applied for, or would not have issued a policy or contract in as large an amount or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise."

Nationwide argues that it would not have issued as much coverage if it had known the true amount of Clay's income.

This argument depends upon Nationwide's position that "average earned monthly income" on the application means "net income" after deduction of office overhead. Nothing on the application compels such a conclusion, but Nationwide argues that its "Agent's Portfolio," introduced as Plaintiff's Exhibit 13, defines income so as to require deduction of expenses. Under "Monthly Indemnity Benefits," that exhibit defines "earned income" as "1. Income before taxes arising from occupation, or 2. Net

income, after expenses, but before taxes, arising from the operation of a business."

The trial court observed that

> "there's no definition of income in the policy. The policy is to be construed against the insured [sic]. There is gross income and there's net income. If a person is disabled to work it doesn't presuppose that he's going to go out and fire his secretary and close his office immediately. He may go back to work in six months. And I would think that it means gross income."

Although the record indicates that the trial court stated that the policy is to be construed against the "insured," this is clearly either a typographical error or a slip of the tongue. The trial court correctly applied the rule that ambiguities are to be construed against the insurer. See the many cases cited in 12 Alabama Digest *Insurance* Key # 146.7(1). See, for example, *Employers Ins. Co. of Alabama v. Jeff Gin Co.*, 378 So. 2d 693 (Ala. 1979); *Alabama Farm Bureau Ins. Co. v. McCurry*, 336 So. 2d 1109 (Ala. 1976); and *Mutual Benefit Health & Accident Ass'n of Omaha v. Reid*, 279 Ala. 136, 182 So. 2d 869 (1966).

Counsel for Clay cited to the court the cases of *Rambin v. Continental Casualty Co.*, 186 So. 2d 861 (La. Ct. App. 1966), *writ refused*, 249 La. 578, 187 So. 2d 740 (1966); and *Allstate Ins. Co. v. Winnemore*, 413 F.2d 858 (5th Cir. 1969). In the former, the Louisiana court held that " 'average monthly earnings' is ambiguous," that " 'earnings' . . . does not necessarily mean 'net earnings' unless qualified in some manner," and that the interpretation most favorable to the insured would be adopted. 186 So. 2d at 864. In the latter case, the Fifth Circuit Court of Appeals stated that even though an innocent misrepresentation

might void the policy, "[W]e think it is possible that if Winnemore did not know or could not be expected to know the meaning of 'earnings' on the insurance application, he did not make a misrepresentation." 413 F.2d at 863.

Nationwide cites *General Accident, Fire & Life Assurance Corp. v. Jordan,* 230 Ala. 407, 411, 161 So. 240, 242 (1935), for the Court's statement, "That [plaintiff] was repaid for his business expenses is not, in our opinion, a part of his earnings." Reimbursement for out-of-pocket expenses, however, is quite different from fees earned by an attorney: in the former case, the individual pays his expenses out of ordinary income, and inclusion of reimbursement as income would cause the sum to be included twice. On the other hand, an attorney would normally consider the entire amount of a fee paid to him as income, and could not be expected to deduct expenses unless specifically instructed to do so.

We agree with the trial court and the cited authorities that Nationwide's failure to tell Clay that "average earned monthly income" means *net* income prevents it from avoiding coverage on this ground. Furthermore, even within Nationwide's internal rules, there is an ambiguity as to whether Clay's law practice would constitute an occupation or a business, and only in the latter instance would expenses be deducted. Finally, the "Relation of Earnings to Insurance" clause of the policy contemplates the use of a two-year period to determine average monthly earnings. In the two-year period preceding the application, Clay averaged over $2,000 income per month even after the deduction of office expenses. Thus, the trial court's decision to rule for Clay on this issue was eminently proper: not only did Clay have no reason to suspect he should give a "net income" figure, but also Nationwide's own rules, interpreted strictly against the insurer, preclude the use of a one-year net income average for a professional, whose income arises from an occupation, not a business.

Nationwide also argues that the trial court erred in granting a directed verdict on the contract count, because Clay represented that he would cancel the Paul Revere policy, but, instead, increased it. This argument has two branches: one, that Nationwide should not have to pay benefits because of the misrepresentation; and two, that the trial court should not have directed a verdict because the existence of other insurance presented a factual question on the amount of benefits due. Clay's response essentially is that he did cancel the existing policy as he said he would do, and the fact that he took out higher coverage with Paul Revere after he obtained the Nationwide policy does not allow Nationwide to avoid coverage under its policy. He asserts that the calculation of benefits due was a simple matter of arithmetic and Nationwide made no objection before the jury retired to the trial court's performing this calculation.

The trial court made the following remarks during argument about the admissibility of evidence on this issue:

> "That's not going to be a defense as far as this Court is concerned. . . . A man notifies an insurance company that he's going to cancel it and the agent comes back out and talks him out of it; it's absolutely clear to me that it's not a misrepresentation if he did what he said he was gonna do. And, that's undisputed, isn't it?
>
> "[Attorney for Nationwide]: Your Honor, it's not his intentions, it's what he does, his actions.
>
> "The Court: Well, you're asking him to be held responsible for what the insurance company caused.
>
> ". . . .
>
> "You know, to me it is just absolutely irrelevant. I mean, because the representation is that he was go-

ing to cancel it. That's what he tried to do. That's undisputed. Then he decides he's going to get another policy. That's undisputed. How the company treated that new policy, he didn't even know about that. What difference . . . I can't see what difference it makes.

". . . .

"I don't know how you can possibly hold an insured to what an insurance company does, how they internally treat something. That's the reason I don't see any relevance."

Paul Revere's agents treated the policy issued to Clay in February 1977 as a "make-over" of the policy he had at the time he applied for the Nationwide policy. Nationwide insists that this indicates Clay did not cancel the existing policy and thus that he made a misrepresentation when he said he would cancel it; and that this misrepresentation gives Nationwide a basis for rescinding its policy.

The difference between increasing the pre-existing policy and taking out a new policy after securing the Nationwide policy comes into play for the following reason: if Nationwide takes an application to supplement an existing policy, it will deduct the existing coverage from the amount of coverage it is otherwise willing to provide. Nationwide will write disability insurance for approximately half of an insured's income, reasoning that more coverage would be "overinsurance," tempting the insured to prolong a disability. Thus, with Clay stating that he made $1800 per month, if he had said he would keep the Paul Revere coverage of $400 per month, Nationwide would have provided only $500 additional coverage.

On the other hand, as a Nationwide underwriter testified, Nationwide cannot control what an insured does after he takes out a policy with Nationwide. Therefore, the policy includes the "Relation of Earnings to Insurance" clause.

This clause provides that, if the total "loss of time" coverage exceeds the insured's monthly income "at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability . . . , whichever is greater," Nationwide will pay a prorated amount of benefits and return the excess premiums.

As it turned out, when Clay made his claim Paul Revere reduced its coverage to $1250 per month with an additional one-year benefit of $150 per month. The trial court calculated the benefits due under Clay's Nationwide policy when it directed a verdict on the contract claim. These calculations were not preserved in the record. Clay, in his appellee's brief, provides calculations which would justify the $46,165.00 award made by the trial court. He states, moreover, that these calculations give Nationwide the benefit of the doubt in three respects: they allow proration of his Nationwide policy in spite of Harker's representation that the Paul Revere, not the Nationwide, policy should be prorated; they allow the relation-of-earnings provision to apply to the $1300-per-month rider, which is inconsistent with Nationwide's position that the waiver-of-premium provision in the policy did not apply to the rider; and they do not give Clay any refund of excess premiums for prorated benefits.

Clay further makes the argument that when Harker denied coverage on the basis of a pre-existing condition, he waived the defense of misrepresentation regarding cancellation of the Paul Revere policy, because he already knew of the $2200 Paul Revere policy.

Nationwide argues that the "stacking" of coverage shows an intent to defraud. Clay's attorney responded at trial that Nationwide had not pled a defense raising this issue, and the court agreed: "It doesn't make any difference how many policies he has unless you are relying upon a defense that he knew he was going to be disabled."

During this colloquy, which occurred during Clay's testimony on the third day of trial, the court remarked:

> "Well I'll just tell you and I'll put it on the record, I'm prepared at this time to direct a verdict for the Plaintiff on the main claim and submit only the issue of bad faith to the jury. I just don't see any, absolutely no defense and I don't understand why this claim was not paid. It's something I must decide. The jury must decide whether or not it was denied based on bad faith. But I don't see any legitimate arguable defense in this case.
>
> ". . . .
>
> "I just don't think at this point, absent some other evidence, that there is any arguable defense based upon the defenses you presented to me . . . ."

Nationwide argues that these remarks were improper because it had not yet begun to put on its case. However, the court did not direct a verdict at this time, but did so only at the close of all the evidence. Moreover, the court stated that its conclusion was tentative, "absent some other evidence."

Nationwide points to the fact that Clay made no answer to the question on the claim form asking whether he had other insurance. The question, however, asked for "any other Companies with whom you may carry Accident & Sickness insurance." Clay testified that he thought of disability coverage as "income insurance" and thought the question meant medical insurance. Indeed, Clay's policy is titled a "Disability Income Policy." See *Mutual Benefit Health & Accident Ass'n of Omaha v. Reid*, 279 Ala. 136, 182 So. 2d 869 (1966), in which the Court held that a clause in a health and accident policy referring to "other insurance" did not include a life insurance policy providing additional benefits for death or disability by accidental means.

At any rate, when he talked to Otey on the telephone, Otey said he was aware of the Paul Revere and National Home policies. Furthermore, the existence of the Paul Revere policy came to Nationwide's attention before Harker denied coverage based on a pre-existing condition, so Clay argues that Nationwide waived any defense on this basis.

We find no error in the trial court's action. Paul Revere issued the $2200 policy after Nationwide issued its policy. Since the higher Paul Revere policy was not in existence at the time Nationwide issued coverage, it could have had no effect on Nationwide's decision to issue its policy. Therefore, while the Paul Revere policy might have an effect on the amount of benefits due under the Nationwide policy, it could not serve to void the Nationwide policy completely.

Neither does Nationwide present any error in the trial court's decision to calculate the amount of benefits due under the contract. The only objections Nationwide made were to the general issue of directing a verdict on the contract count. When the trial court repeatedly stated that it would calculate the benefits, Nationwide made no objection. Neither did it make any effort to preserve a record of the manner in which the trial court made the calculation. Thus the only question presented for our review is the actual decision to direct a verdict on the contract count, and we have resolved that question above.

THE BAD FAITH CLAIM

Nationwide argues that the numerous disputes raised questioning Clay's disability, income, and other insurance show that there were arguable reasons for denying the claim and thus it was error for the trial court to deny its motion for directed verdict on the bad faith claim.

The trial court correctly instructed the jury on the elements of an action for bad faith refusal to pay an insurance claim:

> "An insurer is liable for its refusal to pay a direct claim when there is no lawful basis for the refusal coupled with actual knowledge of that fact.
>
> "No lawful basis means that the insurer lacks a legitimate or an arguable reason for failing to pay a claim. When a claim is fairly debatable, the insurer is entitled to debate whether the debate concerns a matter of fact or one of law.
>
> "In order for the Plaintiff to recover, he must satisfy you from the evidence as to the following things:
>
> "(One) That there was an insurance contract between the parties and a breach of that contract by the Defendant.
>
> "(Two) An intentional refusal to pay the insurance claim;
>
> "(Thirdly) The absence of any arguable or legitimate reason for that refusal; the absence of a debatable reason to pay the claim [sic];
>
> "And, lastly, the insurer's knowledge or actual knowledge of the absence of any legitimate or arguable reason.
>
> "In short, the Plaintiff must go beyond the mere showing of non-payment and must prove a bad faith non-payment. A non-payment without any reasonable grounds for dispute, or, stated differently, the Plaintiff must show that the insurance company had no legal or factual defense to the insurance claim.

> "Whether an insurance company is justified in denying a claim under a policy must be judged by what facts it had before it at the time the decision was made to deny the claim."

We note that these instructions omitted the element of "intentional failure to determine whether or not there was any lawful basis for such refusal." See, e. g., *Cincinnati Ins. Co. v. Little,* 443 So. 2d 891 (Ala. 1983); *National Savings Life Ins. Co. v. Dutton,* 419 So. 2d 1357 (Ala. 1982); and *National Security Fire & Cas. Co. v. Bowen,* 417 So. 2d 179 (Ala. 1982).

Nationwide argues that the element of refusal to pay is lacking because Nationwide made four payments on the claim and ceased only because Clay, instead of providing income information in response to Nationwide's March 28, 1978, letter, filed this lawsuit.

Clay responds that Nationwide's repeated refusals to cooperate justified him in disbelieving the letter's statement that the income information would settle the matter. He states that the course of negotiating the claim—the failure to return his calls, the refusals to locate his file, and the denials of receiving letters and reports (which did in fact turn out to be in his file)—show at least a bad faith failure to investigate, if not that Nationwide's periodic refusals to pay were made with actual knowledge of a lack of an arguable reason.

Clay also argues that Harker's decision to deny coverage based on a pre-existing condition waived a defense of misrepresentation that the Nationwide policy would replace the Paul Revere policy. He says this choice of grounds for denying the claim constitutes a waiver because Harker knew at the time he made this denial of coverage that Clay had a Paul Revere policy in effect. We need not reach this claim that such a waiver shows

that Nationwide later raised the "other insurance" and "insufficient income" grounds in bad faith. There was sufficient evidence of bad faith assertion of these grounds without a finding that Nationwide had waived them as a matter of law.

Harker stated that he decided that Clay might not have sufficient income on the sole basis that Clay had not filed income tax returns, and he refused to explain to Clay why he wanted the income information. This evidence supports a finding that Harker's attempt to have Clay prove he was entitled to coverage was made in bad faith. When this evidence is considered along with the evidence of Nationwide's seriatim assertions of grounds for denying coverage, which were not supported by the facts and documents before Otey and Harker, but only by their assumptions, it becomes clear that the evidence was sufficient to go to the jury on the bad faith claim. Therefore, the court did not commit error in denying Nationwide's motion for directed verdict on that claim.

RULINGS BY THE TRIAL COURT

This group of arguments presupposes that the trial court was in error on the merits on various aspects of the case. Most of the rulings complained of have been set out or discussed specifically above. We need not address the others explicitly because to do so would only require a reiteration of the holdings already made herein.

REMITTITUR

Nationwide insists that the verdict on the bad faith claim was excessive under the facts of the case. We disagree. The uncooperative, intransigent behavior of the Nationwide agents is the very thing the bad faith action is designed to prevent. The verdict is large, but not out of proportion to the wrong.

The judgment is affirmed.

AFFIRMED.

Faulkner, Jones, Shores, Embry, and Adams, J.J., concur.

Torbert, C. J., dissents in part and concurs in part, with opinion, in which Beatty, J., concurs.

Maddox, J., dissents with opinion.

TORBERT, CHIEF JUSTICE (dissenting in part and concurring in part).

I dissent from that part of the majority opinion which affirms the bad faith judgment for Clay. Once again we are faced with a bad faith claim where the facts unquestionably show that the insurer's conduct was not an example of how to properly process a claim made by an insured. To the contrary, the claim was badly handled, but this is clearly not the issue here. And as I said in *Aetna Life & Casualty Insurance Co. v. Lavoie,* [Ms. December 7, 1984] —— So. 2d —— (Ala. 1984), and *Continental Assurance Co. v. Kountz,* [Ms. December 21, 1984] —— So. 2d —— (Ala. 1984), alternatives to the tort of bad faith should be pursued in order to regulate the improper conduct of insurers. However, the question presented here is whether a jury could find that this insurer's conduct rose to the level of "bad faith" as currently defined by this Court.

First, I will address the propriety of the directed verdict on the contract claim. Nationwide contends that Clay's misrepresentation of income on the application entitles Nationwide to void the policy. Obviously, the first inquiry should be whether Clay in fact made a misrepresentation as to his "average earned monthly income." Nationwide maintains that the term "average earned monthly income" means the average of net monthly income, that is, gross

income less expenses. However, there is no evidence that Clay knew that Nationwide meant *net* "average earned monthly income." It is only if neither Clay's net nor his gross "average earned monthly income" was the amount stated that it could be said that Clay misrepresented his income. At trial it became clear that using either a one-year or two-year average of monthly earnings prior to the disability, Clay's gross income was at least the amount stated in the application. Under the two-year average method, his net income also was at least the amounted stated in his application. The trial court's finding that there was no evidence to support the misrepresentation claim was correct.

Clay's level of income was important for another reason. The extent of Nationwide's liability under its "relationship of earnings to insurance" clause was a function of two factors, Clay's income and the amount of loss-of-time coverage Clay held with other insurers. I find no error in the trial court's determination of the extent of Nationwide's liability based upon the information produced at trial.

However, while at trial there was sufficient information from which the extent of Nationwide's liability could be determined, that information was not made available to Nationwide until just before trial. Whether Nationwide acted in "bad faith" depends upon whether at the time of denial of benefits, Nationwide had a debatable reason for denying the claim.[1] On the initial claim form submitted by Clay, the questions asking for monthly income and whether the insured had other insurance were not answered. Subsequently, Nationwide learned that Clay had not filed federal income tax returns for the years 1975, 1976, and 1977. The facts that Clay had not disclosed his

[1] This is clearly a "first tier" bad faith case, as the trial court did not even charge the jury as to the "second tier" of bad faith.

income on the claim form and that he had not filed tax returns for the three years preceding his disability were sufficient to create a debatable reason as to whether Clay had sufficient income to entitle him to the full benefits of the policy. Clay's adamant refusal to reveal any financial information, no matter how justified he may have felt in refusing to answer, certainly served to confirm Nationwide's concerns that Clay's income was not what Clay originally represented in his application.

I believe that Nationwide had a debatable reason for questioning the extent of its liability and that the existence of this debatable reason precludes a finding of bad faith.

Beatty, J., concurs.

MADDOX, JUSTICE (Dissenting).

I believe there was at least a "scintilla" of evidence of a factual dispute between the parties over whether the terms "average earned monthly income" in the policy meant "net income" after deduction of office overhead; therefore, a directed verdict on the contract count was error, in my opinion. On the bad faith portion of the claim, I remain convinced that these disputes could best be resolved by the procedure I outlined in my dissent in *Continental Assurance Co. v. Kountz* [MS. 82-793, December 21, 1984], —— So. 2d —— (Ala. 1984).

APPENDIX J

SUPREME COURT OF THE UNITED STATES

No. A-728

AETNA LIFE INSURANCE COMPANY, *Appellant,*

v.

MARGARET W. LAVOIE AND ROGER J. LAVOIE, SR.

ORDER

UPON CONSIDERATION of the application of counsel for the appellant,

IT IS ORDERED that the judgment of the Supreme Court of Alabama, case No. 82-426, entered December 7, 1984 is stayed pending receipt of a response to the application and further order of the undersigned or of the Court.

THIS ORDER is conditioned upon posting with the Clerk of Mobile Circuit Court of a good and sufficient bond. Said bond is to be conditioned upon the full satisfaction of the judgment of the Alabama courts, with costs and interest and damages for delay, if for any reason this appeal is dismissed or the judgment is affirmed.

/s/ LEWIS F. POWELL, JR.
Associate Justice of the Supreme Court
of the United States

Dated this 26th day of March, 1985.